from ASYLUM to WELFARE

Harvey G. Simmons

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For

Eileen
Erica
Leah
Daniel

and my mother.

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INTRODUCTION

During the nineteenth century there were two major approaches to the study of social policy: an idealist approach most closely associated with the work of the English jurist A.V. Dicey, and a materialist approach derived from the writings of Karl Marx. Recently, a large number of interpretations have been added to these two: the behaviouralist, bureaucratic, positivist, decision-making, phenomenological, and labelling approaches are just a few. Some are refinements of either idealism or materialism, others are *sui generis*. Some, such as the decision-making approach tend to focus narrowly on a particular decision or series of decisions taken at one instant of time, others are more sweeping in scope, surveying vast areas of social policy and ranging freely over the decades. Some take a consensual approach and see the evolution of social policy as an inevitable concomitant of larger historical processes such as the coming of industrialization, urbanization, economic progress or the rise of the welfare state, while others interpret the rise of social policy in terms of class or political conflict.

In this case, I have followed what can best be described as an eclectic approach. The study is organized along chronological lines, with the major periods being those from 1831 to 1900, from 1900 to 1945, and from 1945 to 1980. These years were chosen because it seemed to me that during each period a particular and unique combination of influences impinged on policy, although as policy evolved new influences made themselves felt, and were re-shaped into different patterns. While I have tried in the first instance to describe the essentials of mental retardation policy over the decades, I have also generalized about why policy assumed the shape it did and offered some general explanations of policy formation. Above all, I have tried to describe the process of policy-making from the point of view of the policy-makers themselves, and to avoid imputing motives which they did not have. Studies of social and public policy sometimes imply that policy-makers are manipulated by larger historical forces over which they have no control, but which push them in unwanted and often unexpected directions. Thus, policy is interpreted as serving both a manifest function (which describes those consequences intended by policy-makers) and a latent function (which describes the unintended consequences of policy).

It is often assumed that policy-makers are unaware of the latent functions of policy and that only the outside analyst or scholar realizes what the "real" functions of policy are. But it seems to me that the reason policy-makers do not achieve intended goals is not because they are the victims of outside forces, but because there are always contending ideas about policy, and contending forces which may inflect policy in a direction quite different from that intended by the ostensible policy-makers. What seem to be the unintended consequences of policy often turn out,

on closer examination, to have been consequences unintended by some, but intended by others. Thus, it is not "history" or its minions such as "class," "industrialization," or "urbanization" which shape policy, but rather people acting within social roles. Certainly structural variables set the context and shape these roles, but policies can assume an infinite variety of forms within any specific context. For example, mental retardation policy in one jurisdiction may be oriented towards care in large custodial institutions, while in another it may be oriented towards small institutions and community care. Both policies are generally known as, and termed "mental retardation policy" but in substance they diverge. This is why one must probe beneath the surface in order to reveal the actual substance of policy.

There is now an enormous literature which attempts to explain social policy in terms of quantifiable variables such as the rate of urbanization, economic growth, government expenditure, or even the degree of political party conflict. But correlations are not causations — nor are they explanations. The difficulty with these approaches is that there is no explanation of the logic or rationale behind policy-makers' decisions. Policy — and even lack of policy — is a result of a political choice, and one cannot understand the process of policy-making without understanding why policy-makers do or do not make certain choices. Whereas in the past scholars argued that political ideology had little influence on policy, recent studies indicate that the role of political ideology is quite important in determining the shape of public welfare decisions.

Yet there is a degree of truth in the seemingly contrary findings that politics does or does not affect policy outcomes. Since most studies of social or public policy lack historical perspective, they miss the important fact that there are periods in history when policy-making takes place in a humdrum, routine fashion, largely unaffected by the major political conflicts of the age, while at a different point in time, the same policy may be the focus of heated political debate. Of course, political ideology always matters to some extent since it shapes the context within which politicians and bureaucrats act, but the degree to which ideology directly affects policy varies over time.

This is the case with the evolution of mental retardation policy in Ontario. From 1831 to 1900 policy resulted largely from the activities of a few bureaucrats, mainly government inspectors appointed to supervise the activities of the various provincial public institutions, and from the action of the politicians directly responsible for them. During this time, the ebb and flow of political conflict had little direct effect on mental retardation policy. But from 1900 to 1930 the influence of the English eugenics movement made itself felt as the myth of the menace of the feeble-minded appeared in Ontario. This provoked the formation of a series of pressure groups which, along with the press and local politicians began to campaign for major changes in mental retardation policy. From approximately 1930 to 1945, however, policy again lapsed back into the

hands of government policy-makers. The issue of the feeble-minded faded from the public scene as government bureaucrats and institution superintendents shaped policy pretty much immune from exogenous influences. By the 1950's a unique new element in the form of a parents' pressure group came upon the scene. Now policy resulted from a number of influences including the Ontario Association for the Mentally Retarded, the bureaucracy, political parties, the press and the public.

Because the pattern of influence that shapes policy over the long term shifts and changes, it is dangerous to generalize about the evolution of policy on the basis of just a few years or even decades. Perhaps it is simply dangerous to generalize at all, since like other human activities politics is infinitely creative, and what happens in the future can rarely be predicted from a knowledge of what happened in the past.

Nevertheless, I have argued that since 1831 mental retardation policy in Ontario has tried to achieve four major objectives: to provide asylum for mentally retarded people who could not physically survive in the community without government help; to educate mentally retarded people defined as being educable; to impose some kind of social control on mentally retarded people who were defined (or labelled) as delinquent or immoral, and to provide social welfare for mentally retarded people who would have been physically capable of surviving in the community, but who could not do so because of lack of employment, because they had personality or behavioural traits which led the community to reject them, or because of the absence of a social service infrastructure appropriate to their needs. Furthermore, in tracing the history of policy I have tried to show how the various structures and services associated with mental retardation policy (the custodial institutions such as Orillia, special classes in the school system, parole programs in the 1930's and community care programs in the 1970's) were used to achieve one or another of these objectives. And in each case and for each period I have tried to show how policy resulted from the play of the various influences which impinged on policy.

There is also the question of what is meant by the term "mental retardation policy." Very early on the government of Upper Canada tried to ignore the mentally retarded people who were found in the first lunatic asylums established in the province. Nevertheless the authorities were forced to deal with them, initially by barring them from admittance to the lunatic asylums and later by providing special facilities for them along with others labelled as "chronically insane." This was policy by inaction, or inadvertance, for by establishing a lunacy policy and deliberately trying to ignore mentally retarded people, the authorities in Upper Canada nevertheless found themselves making policy regarding mentally retarded people. Thus on occasion the term "policy" refers to government actions which indirectly affected the fate of mentally retarded people. However, with the establishment of the Idiot Asylum at the London Lunatic Asylum in 1872 the government embarked upon a policy specif-

ically aimed at mentally retarded people. But the term "policy" still blurs at the edges, for mentally retarded people are not just or only mentally retarded, but like other people they may be senile, delinquent, single mothers, poor, unemployed, etc. — that is, they may fall within the scope of government programs and policies aimed at a variety of social problems. However, when it appeared to me that the authorities were aware of the presence of mentally retarded people in these programs, even if no explicit provision was made for them, I have used the term mental retardation policy to refer to the attitudes and actions which shaped these programs.

I have not entered into the problem of defining mental retardation. This is a study of what government has done to and for those they have defined as mentally retarded. Since each generation has its own set of criteria and definitions I have accepted those used by the policy-makers of the period under discussion, although I have also pointed out that many people who were not mentally retarded often fell within the scope of mental retardation policy. The continued presence of non-mentally retarded people in mental retardation programs throws some light on what mental retardation policy was supposed to achieve and how those who fell within it were regarded by the authorities and by the public. Finally, in the early part of the book I have used terms such as "idiot," "imbecile," "moron," or "feeble-minded." This is done for the sake of consistency and is in keeping with the vocabulary of the time. Obviously, I have no pejorative intention in using this vocabulary, and the terms are abandoned when referring to the period after 1930.

PRELUDE

On the last day of 1959, Pierre Berton, a well-known columnist with the Toronto *Star*, Jerry Anglin, institutions chairman of the Ontario Association for Retarded Children (later the Ontario Association for the Mentally Retarded) and Anglin's twelve-year-old retarded son Mark drove from Toronto to return Mark to the Ontario Hospital at Orillia. Berton had heard some disturbing rumours about poor conditions at Orillia and had decided to visit the institution, but fearing the staff there might not be completely frank, he invited Anglin to go along. While Berton and Anglin were chatting in the front seat of the car, Mark became sick and vomited in the back. This was his reaction to returning to Orillia. Upon their arrival Berton was shown around the institution and given a tour of some of the oldest and worst buildings. Six days later, under the heading: "What's Wrong at Orillia: Out of Sight, Out of Mind," Berton wrote about what he had seen. There were, he claimed, 2,807 people in facilities for 1,000 while 900 of the residents were housed in seventy-year-old buildings. "It is distressing to visit these older buildings.... The thought of fire makes the hair rise on your neck...the paint peels in great curly patches from wooden ceilings and enormous, gaping holes in the plaster show the lathes behind. The roofs leak, the floors are pitted with holes and patched with plywood.... The beds are crowded together head to head, sometimes less than a foot apart. I counted 90 in a room designed for 70. There are beds on the veranda. There are beds in the classroom.... The stench is appalling even in winter. There are 4,000 names on file at Orillia and an active waiting list of 1,500 people who have written in the last year. Political considerations have made Orillia's situation more acute. The hospital was originally designed for children six years and older. It is now heavily crowded with children under that age.... Orillia's real problem is political neglect."

Part I

1831-1900

1

From Non-Policy to Policy

When it first embarked upon lunacy policy in the late 1830's the government of Canada had absolutely no intention of dealing with mentally retarded people. During the first part of the nineteenth century municipalities had petitioned the House of Assembly of Upper Canada asking that something be done about the mentally ill and retarded ("lunatics" and "idiots"), but these requests had gone unheeded. From 1831, bills were unsuccessfully laid before the House of Assembly of Upper Canada specifically proposing the establishment of a lunatic asylum.[1] Finally, in 1835, the House of Assembly appointed a committee of three doctors to look into the question. The head of the committee, Dr. Charles Duncombe, travelled to the United States, visited a number of institutions, and in 1836 laid his report before the House of Assembly. He was glowing in praise of the American institutions and full of optimism about recent developments in the treatment of the insane and the prospect for a successful lunacy policy. In Duncombe's opinion everything connected with lunacy policy had recently undergone a marked, beneficent change. "The improvements recently made in the construction of hospitals for the insane, having reference to their comfort and classification in particular, have been so important, as to change materially the former character of these establishments."[2] Equally important, Duncombe remarked that if the treatment "will be chiefly moral" then up to 90 percent of the cases might be cured. "The insane are no longer treated as the outcasts of society, or considered as unworthy of further regard than to be confined in common jails or poor houses. Their diseases are found to be curable like other disorders of the human system."[3] Finally, Duncombe argued that it was cheaper to build an asylum rather than to let the insane languish

in local jails, or wander abroad and depend on local charity. After all, he argued, since the localities were already spending a lot of money on the insane, it would be more economical to add these small sums together and use the interest to finance the construction of a proper asylum. The advantage was that, unlike local institutions, a good asylum could cure the vast majority of the insane.[4]

Duncombe's enthusiasm for the curative possibilities of moral treatment was widely shared not only in the United States but in France and Great Britain as well, for the work of Philippe Pinel in France and the Tukes at the York Retreat in England had indicated that the new methods of moral treatment could dramatically increase the number of cures. Although there was not a word about mentally retarded persons in Duncombe's report, there is nothing surprising in this omission, for the work of the two major pioneers in educating mentally retarded children in North America, Samuel Gridley Howe and Edouard Seguin would not become public knowledge until some ten years later. Nor is it likely that Duncombe or his fellow committee members knew about, or even if they had, would have been able to make much of the report that Jean Marc Gaspard Itard laid before the Society of Observers of Man in 1801 concerning his attempts to educate the Wild Boy of Aveyron. Most likely, if the Upper Canadian policy-makers thought at all about mental retardation, they probably shared the conventional view that idiots were basically incurable. Since contemporary lunacy policy was directed toward curing the insane, it is easy to understand why idiots were excluded from their report and from the policy that emerged from it.

As a result of the Duncombe report, on May 11, 1839 the House of Assembly passed: "An Act to authorise the erection of an Asylum within this Province for the reception of Insane and Lunatic persons."[5] Since Sir George Arthur, the Lieutenant Governor, seemed to favour locating the asylum in the city of Kingston, a controversy then ensued about where the asylum should be built. On June 10, 1840, the College of Physicians and Surgeons in Toronto sent the Lieutenant Governor a message asking that the asylum be located in Toronto. "It certainly could not have escaped Your Excellency's penetration that such an establishment as a lunatic asylum should be so situated that it would afford to the friends of the pitiable objects for whose accommodation, protection and cure it is founded the assurance of their receiving the most efficient and popular professional aid that could be obtained in the province.... The presence of an institution for the cure of mental diseases as an adjunct to the present practical benefits offered by the general hospital will present to the student of medicine advantages of an importance that he should not:..be deprived of."[6]

Thus, the curative goal of the asylum was a major reason given by the College for locating the asylum in Toronto. Perhaps as a result of this argument, the Provincial Lunatic Asylum opened in Toronto on January 21, 1841, at first in temporary quarters in the old county jail, on King

Street, and then, on January 26, 1850 in the magnificent building at 999 Queen Street West, designed by the Toronto architect, John G. Howard and described at the time as "exceedingly handsome, commodious, healthful and safe...a monument to the Christian liberality of the people."[7]

When the PLA opened in the old jail, the departing Sheriff left behind seventeen insane ex-prisoners. The report of the visiting commissioners appointed to oversee the asylum notes that they were taken from their cells where they had been immured in filth, "carefully washed, clothed, and placed under Medical care; their food critically adapted to their physical state. The effect of this new course of life was soon apparent; many who had long been confined as confirmed Lunatics were found to be labouring, not under mania, but under derangement arising from physical causes and yielding to physical remedies." In a statement appended to the report for the six months from January 21 to July 31, 1841, it was also noted that of the thirty-two patients admitted during that period, one died, "8 were discharged as cured, three were convalescent and 16 relieved."[8] On this hopeful note the Provincial Lunatic Asylum began its life.

Despite the early optimism surrounding the curative possibilities of moral treatment, the first few years of the Asylum's existence were checkered. Between 1841 and 1853 five successive physicians held the post of medical superintendent. During the tenure of Dr. William Rees, J.H. Tuke, grandson of the famous Samuel Tuke of the York Retreat, paid a visit to the PLA on September 30, 1845. He recorded his reactions in his diary:

> It is one of the most painful and disgusting places I ever visited.... There were perhaps seventy patients upon whose faces misery, starvation and suffering were indelibly impressed. The doctor [at that time Dr. William Rees] pursues the exploded system of constantly cupping, bleeding, blistering and purging his patients, giving them also the smallest quantity of food and that of the poorest quality.... Strongly built men were shrunk to skeletons, and poor idiots were lying on their beds motionless as if half-dead. The doctor in response to my questions and evident disgust persisted that his was the only method of treating lunatics and boasted that he employs *no restraint* [Tuke's italics] and that his cures are larger than in any English or continental asylum![9]

Yet Rees frequently used the term "moral treatment" in his reports and referred to authorities such as Esquirol and Pinel in his correspondence with the Upper Canadian authorities, although mainly to adduce support for his claim that the medical superintendent should be the supreme administrative authority in the asylum.[10] Tuke's observations not only call attention to the rather idiosyncratic interpretation Dr. Rees gave to moral treatment, but to the fact that mentally retarded people were present in

the asylum from the very beginning. Six years after Tuke's visit, however, the Directors of the PLA noted the continued presence of mentally retarded people in the institution and passed a by-law forbidding their admission. "It has been found necessary to exclude all idiotic and paralytic cases — one of which class might occupy the room which in a year, might suffice for three or four patients who, in succession might be received and cured — but of these incurable idiots there is now a large number in the Institution."[11]

The Inception of the Fobbing-Off Process

Three years after opening in the Howard building on Queen Street, and after a continuing series of scandals and investigations regarding the various superintendents, Dr. Joseph Workman was given temporary charge of the asylum on July 1, 1853 replacing the outgoing superintendent Dr. John Scott. A short time later he became permanent medical superintendent, a post he held until July 19, 1875. Both because of his position as head of the PLA, and because of the force of his personality and high intelligence, Dr. Workman was a major influence on the course of policy toward the mentally ill during the third quarter of the century.

Workman was born on May 26, 1805 in the County of Antrim, Ireland, and emigrated to Canada in 1829, arriving in Quebec on May 15. He was graduated as an M.D. from McGill in 1835 and moved to Toronto in 1836 where he worked as a hardware merchant. Workman kept up his professional reading, and finally retired from the hardware business in 1846 to resume private medical practice. He was then appointed to the Chair of Obstetrics and Therapeutics under Dr. John Rolph in the Toronto School of Medicine. Interestingly enough, Rolph had joined with Dr. Charles Duncombe, later to report on lunacy policy to the House of Assembly in 1836, to establish a school of medicine in the city of St. Thomas in 1824. But by 1853 Rolph was a Cabinet Minister and it was at his urging that Workman was appointed to the job at the PLA.

As superintendent Workman immediately adopted the methods of moral treatment, and practised them accordingly — unlike Dr. Rees. Workman was also a journalist of high repute, for many years he was an editorial writer for one of the Toronto newspapers, while his annual asylum reports were lucid, witty, and comprehensive. He was President of the Medical Association of Canada, and President and a founding member of the Ontario Medical Association as well as president of the Medical Society of Toronto. He was also the first North American to be elected to honorary membership in the Medico-Psychological Association of Great Britain.[12]

Given his reputation and his position as head of the PLA, it is important to note that this "Nestor of Canadian specialists" as Daniel Hack Tuke called him had practically nothing to say about the etiology or nosology of mental retardation. Rather, Workman went along with the prevailing sentiment in Upper Canada that idiocy was incurable and that

the presence of mentally retarded people in the PLA constituted an obstacle to the treatment and cure of the insane. In his report of April 5, 1855 Workman observed that "the Governing bodies of the American Asylums have authorized the removal of incurable patients, and the selection in new admissions of recent cases of Insanity to the exclusion of those of long standing and of consequent hopeless character."[13] There is no question that Workman, as well as the government inspectors appointed to oversee the asylum and prison system thought of mentally retarded people as "incurable" and were intent on finding some means of keeping them out of the asylum. But mentally retarded people continued to find their way into the PLA.

One reason was that local doctors were sometimes ignorant of any distinction between mental retardation and mental illness, lumping both together under the category of lunatic. Another reason was that in contemporary statutes the term lunatic often subsumed the term idiot. For example, an 1851 statute authorizing the "confinement of Lunatics in cases where there [*sic*] being at large may be dangerous to the public," says: "'Lunatic' shall mean every insane person, and every person being an Idiot or Lunatic, or of unsound mind."[14] Many doctors must have assumed that idiots were certifiable as lunatics under the statute. Thus, in 1855 Dr. Workman noted the "case of the Idiot George Bourke, some time ago brought here under warrant from His Excellency the Governor General, and duly certified by medical examiners as a case of Lunacy."[15] And, most important, many people who were not mentally ill, but mentally retarded, senile, criminal, unemployed, poor, or unwanted by families and municipalities and vulnerable to the authorities were deliberately certified as insane when they were nothing of the kind.

On February 12, 1855 Dr. Workman complained that violent criminals were often sent to the PLA from the provincial penitentiary and county jails under the pretence that they were insane when, "in several cases of convicts reported to His Excellency the Governor General, hardly a doubt could be entertained as to the imposture which had been practised."[16] And three years later he noted in his annual report for 1858: "The usually assigned causes of insanity as set forth by the relatives or the medical examiners of lunatics, in the certificates furnished at the time of admission are, in nineteen cases out of every twenty, entirely fallacious."[17]

Throughout Upper Canada, therefore, a constant stream of poor, elderly, mentally retarded and senile old people moved from families to the community jails, from the jails to the insane asylums, and then, within the asylums, into different treatment categories. This phenomenon was not peculiar to Upper Canada but was inherent in the asylum system in North America and in Great Britain as well. In accordance with their founders' intentions, the asylums constantly battled to maintain their integrity as institutions for curing the insane. From the very beginning, however, other forces in society tried to use the asylum as a dumping

ground for unwanted deviants, or as undifferentiated welfare institutions for those people whom families and municipalities could not, or would not care for. In 1860, for example, Dr. Workman noted that: "In the present hard times, no doubt the 'authorities' regard every person, who has nothing to eat, as dangerous to be at large; and as the Asylum is known as a good boarding-house, they conclude that it cannot be turned to better purpose than that of relieving themselves of the duty of supporting the poor."[18]

Although this "fobbing-off" process occurred almost everywhere asylums were located, the exact nature of the process was mediated by specific social and political factors. In Canada, there were two main reasons why the PLA began to feel the effects of this process from such an early date: the absence of alternate local welfare institutions for disadvantaged groups, and the method by which the PLA was funded.

In 1792 it had already been decided not to introduce the English Poor Law into Canada. Thus, even if they had wanted to, the 1792 statute effectively prevented the authorities from using local taxes for outdoor relief of the poor. The immediate result was that the burden of caring for the poor, the mentally ill, the retarded or unemployed fell on public charity, or on local institutions. In the case of Upper Canada this meant the local jails. And, despite the passage of a series of acts from 1837 on providing for the erection of houses of industry or houses of refuge, local governments obstinately refused to build any institutions for the relief of the poor until well into the 1860's.[19] Whereas in most of the United States local welfare institutions had been established either before, or simultaneously with the erection of the asylums, in Upper Canada the opening of the PLA preceded the foundation of local welfare institutions by three decades. It is not surprising, therefore, that the medical superintendent immediately began to complain about the fact that families and municipalities were shipping their unwanted problem people to the PLA.

Another reason also militated in favour of this fobbing-off process. The 1839 act authorizing the creation of the PLA stated that funds for construction and maintenance were to be obtained from a special Lunatic Tax levied on "inhabitant householders" throughout the province. This Act was repealed in 1853 and subsequently revised, but the principle whereby the capital and maintenance expenditures for the PLA and for the other asylums were obtained from the municipalities on the basis of property taxes remained the same.[20] This meant that it was in the interest of the municipalities to send people who wound up in local institutions to the PLA; otherwise the municipalities would be forced to pay for their maintenance.

Exactly the reverse situation held in most of the United States, for during the early years of the nineteenth century, municipalities had established local institutions such as almshouses, as well as occasionally adding separate accommodation for the insane onto the local jails. In order to prevent the municipalities from passing the burden of support for these

people onto the government by shipping them to the state institutions, the municipalities were obliged to contribute to the maintenance expenses of all patients sent to the state asylum. Since these charges were almost always more than the cost of maintenance in local institutions, municipalities preferred to keep people in jails or poorhouses. In New York State, for example, municipalities were charged $2.00 per head per week for every pauper sent to the asylum for the chronic insane.[21]

However, since there were no poorhouses in Upper Canada, and given the scandalous conditions in which mentally ill and retarded persons were kept in local jails, the Canadian authorities refused to countenance the idea of returning the incurable insane to the municipalities. In 1865, Doctor Workman observed:

> Many of these poor people are perfectly harmless, and not a few are very industrious, but they are friendless and houseless, and in the absence of any public provision for their comfortable lodgment and support elsewhere, their detention in the Asylum is not only a matter of necessity, but of simple Christian benevolence.... In several of the neighbouring States...legal provision has been made under which the authorities and Medical Superintendents of Asylums may discharge and send back to the places from which they may have come, such Patients as remain uncured after a certain period of treatment. This harsh measure is had recourse to under the allegement that Lunatic Asylums should be paramountly regarded as hospitals for the cure of insanity and not as almshouses for the permanent support of its victims. I have met with no Medical Superintendent of any Asylum in the United States, who has not deplored the necessity of having recourse to this measure. The community or the Legislature which permits such a necessity to exist, is guilty of a heinous offence against the laws of the Divine Ruler of the world, and shows a reckless disregard of the normal obligations of the Christian dispensation.[22]

Most important, mentally retarded people comprised a large part of those who would have been returned to the municipalities, since they were generally subsumed under the category of incurable insane. In 1862, for example, the Chairman of the Board of Inspectors of Prisons, Asylums and Public Charities of Canada, J.C. Taché noted that in the United States "incurables, imbeciles and idiots of the poorer classes" were sent to the county poor houses where they were treated abominably. He referred to the "vast number of loathsome pig-sties" at various places in the United States as "not to be imitated by Christians."[23] We should keep in mind here the fact that mentally retarded people in most American States were barred from state asylums since lunacy policy was still based on the assumption that the best treatment should be reserved for those who could be cured. And in places like Massachusetts where

special institutions for mentally retarded people had been established, they were small and limited to the educable retarded. Thus, despite the existence of a few progressive and humane institutions such as the Massachusetts School for Idiotic and Feeble-Minded Youth, Taché was not exaggerating when he characterized the treatment of mentally retarded people in the United States in such lurid fashion.

In Upper Canada the legislators had the power to compel the municipalities to provide institutions for incurables, but did not do so, while the inspectors who might have forced the asylums to return mentally retarded people to the municipalities because committed under false pretences, would not do so. The result was that in Upper Canada, and then briefly for a few years after 1867 in Ontario, mentally retarded people were housed in the major lunatic asylums, among which the PLA was thought to be one of the best on the continent.

What explains the policy-makers' actions? In the first place there was resistance from the municipalities to the expenditure of funds for houses of refuge and to the idea of sharing the costs of the provincial asylums. The inspectors and the medical superintendents did criticize the municipalities for their reluctance to assume some of the financial burden, but there was little they could do on their own.

The result was that the asylums began to rapidly fill with incurables, and particularly with mentally retarded people. It soon became obvious that the curative goals of the asylum were being undermined by the pressure of numbers. However, given the refusal to turn the incurables out of the asylum, what alternatives were there?

One obvious answer was to provide more accommodation. Over the years the inspectors pressured the government to complete the two wings of the PLA, originally intended to house approximately 300 patients, but uncompleted until 1869. The inspectors also advocated the construction of additional asylums in Upper and Lower Canada as well as objecting, unsuccessfully as it turned out, to the establishment of a small lunatic asylum in an old hotel in the town of Orillia, 60 miles north of Toronto, because "it would be better for various reasons of economy, and for other reasons to establish two or three large Asylums (as need may require) in each section of the Province, than to make a distribution of small establishments, far apart, which are only to receive patients through the parent institution."[24]

But the issue that provoked the most heated debate among North American asylum authorities during this time concerned the question of building separate asylums for the incurable and curable insane. There were two major issues: would the establishment of separate asylums for the curable and incurable insane prejudice the treatment of the incurable insane; and was separation the best method for coping with the appalling conditions in which the incurable insane were found in jails and workhouses?[25] Some authorities argued that separation would facilitate curing those who could be cured, while careful regulation and inspection would

ensure proper treatment of the incurable insane. Others argued that the mere fact of constructing special asylums for the incurable insane would necessarily condemn them to inferior treatment.

In Upper Canada the problem of overcrowding and the question of separate asylums had been met only a few years after Workman had assumed office by opening a branch asylum of the PLA in 1857 in a University of Toronto building three miles from the main asylum. Workman's intentions are quite clear from his description of the fifty-five women and six men who were the first patients in the University Branch. "They are," he said, "quite docile and harmless; a majority are incurable and have been Asylum inmates for many years."[26] So "admirably" did Workman think the University Branch was working, that he recommended the establishment of additional branches as "indispensible" to cope with the large number of incurables who would necessarily find residence in Canadian asylums.[27] There was no question in Workman's mind about the necessity of retaining the incurables in the asylum as long as the method of financing the PLA out of general revenues remained unchanged and the municipalities refused to agree to an acceptable alternative to the PLA. The authorities responded by opening the Malden Branch Asylum on the site of Fort Malden in abandoned military barracks in Amherstburg on July 14, 1859, and on August 13, 1861, a third branch asylum in a half-finished brick hotel on Lake Couchiching outside the town of Orillia. In all three cases the branch asylums received patients through the PLA, and although Workman and his staff were able to supervise the operations of the University Branch because of its proximity to the PLA, the government appointed medical superintendents and staff to administer Malden and Orillia. But both Malden and Orillia were makeshift solutions, Malden because the inspectors feared that in the event of a future war between the U.S. and Canada, the asylum would have to be re-converted to military uses, Orillia because the building and grounds were insufficient to accommodate the patients. Thus, they recommended the completion of the original plans for the PLA, which had provided for two wings for 300 patients, but which had never been built; and the construction of a new asylum in Upper Canada.[28]

By this time the problems of overcrowding with the incurable insane and mentally retarded had become so intense that Workman declared himself a partisan of separate asylums. This was a departure for Workman, since he had previously argued that the branch asylum system differed from the separate asylum system in that the former was simply a method of enlarging the capacity of the main asylum, while retaining all the benefits of central administration and control. Moreover, given Workman's oft-repeated criticisms of those American states where the state asylums returned incurables to the municipalities, and the fact that there was not much difference between the American system and the dual asylum system, the editorial writer of the *Journal of Insanity* expressed surprise at this apparent change of heart. "This gentleman [Workman]

has always been the strenuous advocate of the enlargement of the Toronto Hospital and as we had supposed had viewed with disgust the little incurable establishments thrust upon him by the Inspectors of Asylums and Prisons."[29] But Workman differentiated between his plan and the "heartless and barbarous system based on total ignoration [*sic*] of the claims of mental affliction on national philanthropy practised by the neighbouring Union" where the insane were thrown back on municipal institutions, and the Upper Canadian system of provincial funding, administration and supervision. Workman then recommended the establishment of a system of primary and secondary asylums, with the former caring for the curable insane, and the latter for the incurables.[30] Whereas the primary asylums would continue to depend on the province for financing, the secondary asylums would be located in, and funded by contiguous groups of counties scattered throughout the province. The secondary asylums would receive those patients who remained unrecovered after two years in primary asylums.

Workman's criticism of the practices of "the neighbouring Union" and his suggestions for reform had been inspired by the report of Dr. S.D. Willard of New York State. Willard had found that the insane poor returned to county poorhouses lived amidst "an excess of human misery, degradation and wretchedness that wrings a cry of distress from the heart of every philanthropist."[31] As a result of his report, and then of his death, New York State recommended the establishment of the "Willard Asylum for the chronic insane and for the better care of the insane poor" in April 1865. The Willard Asylum was to perform the role of secondary asylum sketched by Workman, that is, it would take patients who remained unrecovered after two years in the Utica State Asylum, or directly from the county poorhouses. However, Workman's scheme endorsed the highly centralized Upper Canadian administrative system whereby the medical superintendent and the inspectorate remained exclusively under government control. The municipalities would merely provide maintenance funds for the patients.

Although the government did not adopt the proposal in its entirety, during the period leading up to Confederation the branch asylums came to perform the role of secondary asylums, taking the incurable insane and mentally retarded from the PLA and the other asylums.

Writing just one year after his brother's scheme had appeared, Dr. Benjamin Workman, Dr. Joseph Workman's assistant at the PLA, provided a justification of the branch asylum system in Upper Canada:

> Our branch asylums are placed on a higher platform than town or county poor-houses. They are conducted by officers subject to no local or party influences and are not impaired in their efficiency by a niggardly economy, which would place among the improvements of social science, the keeping in existence the chronic lunatic at the lowest possible cost. The diet is plain, but generous and abundant:

> the clothing furnished is warm and substantial. The patients are not subject to such harsh treatment as is too often enforced in town and county pauper institutions. Non-restraint is adopted in all possible cases. Cleanliness is maintained; good ventilation is attended to; and amusements, and various kinds of recreation are encouraged. In these retreats there is no gloom. The shadow of hopelessness or despondency does not darken the path of these inmates. They are cheerful under a mild regime.[32]

In the following years the inspectors' reports testified to the accuracy of Benjamin Workman's description of the branch asylums as adequate, but spartan institutions, although no one seems to have observed the patients in a cheerful mood, or even one that could be described in terms of "lack of gloom." Two characteristics of the branch asylums do stand out: they were tenanted by large numbers of mentally retarded people; and they were expected to cost less than asylums for the curable insane. In 1862, for example, Wolfred Nelson, Chairman of the Board of Inspectors, wrote of Orillia: "There is unfortunately enough of this class [idiotic and imbecile] in Upper Canada to people this Institution, and their assemblage here would be beneficial not only on ground of expense, but also because their separation from the others is called for on every consideration." And the following year he noted of Orillia that "idiocy, imbecility and helplessness" predominated among the patients. "They cannot be put to any work and pass their time in moping and listless state; hence there is little reason to regret that the premises are contracted."[33]

In the same report, inspector James Moir Ferres also expressed his thoughts about the quality of care appropriate for mentally retarded people:

> All the treatment they [the idiotic] require is simply for such occasional bodily ailments, as a common humanity makes them liable to, and for which any physician can administer. The buildings for this class of unfortunates need not be of the same expensive character as is required in those for the insane, and so of the attendants.... The fatuous and the cretin, with their mental faculties obscured from their birth are beyond medical skill, and generally stolid, they require no other attention than a regard for cleanliness demand. They may, consequently, be as well cooped up in a jail if it is so desired as anywhere else. The lunatic, on the other hand, requires the regular attention of a physician....[34]

According to Ferres, the distinction between a "person labouring under insanity whether curable or incurable" and an "idiot or cretin" was so obvious even to a layman that the necessity of separate asylums for the two groups was self-evident. "While the daily and hourly changes in the various phases of dementia require the constant watchful attention

and thoughtful reflection of the keenest intellect of the physician, that he may catch the favourable turn which is to give him hopes of cure, the unvarying stolidity of the idiot offers no such chances for the patient, nor does it demand such services nor skill from the medical attendant." Therefore, Ferres argued, asylums for the insane should not be encumbered with "a class who are not insane." Moreover, he suggested that until two separate classes of asylums were established, the statistics on insanity would be valueless. On the basis of this evidence, Ferres argued that separate asylums for idiots required less space, and staff who did not need the higher qualifications necessary to care for the insane. "While the one is dangerous to himself and to others, when at large, the other can as well be taken care of in the private family, as in the public institution. For the one the asylum is a necessity, for the other it is made available as a convenient means of riddance." Finally, Ferres said that the municipalities rather than the province should, in the case of the idiotic, "be called upon at least to share the burden of supporting those within their limits, whom God has seen fit to render helpless in supporting themselves."[35]

What we see here is an explicit justification of a fobbing-off process even where serious questions can be raised about the facts assumed in the argument. For example, if we grant that those identified as idiots had identifiable physical stigmata (thus Ferres' claim that practically anyone could distinguish between the insane and the idiotic), it is difficult to understand how Ferres could believe that the physician in an insane asylum could possibly watch the "daily and hourly changes in the various phases of dementia" when, in the case of the PLA in the 1860's there were two physicians, Dr. Workman, assisted by his brother Benjamin, to watch between 350 and 400 patients. Ferres was obviously so possessed with the notion that the success of the asylum had to be judged by its ability to cure that he was willing to marshall practically any argument to support the idea of ridding the asylum of incurables. Thus, the best patients, those who could be cured, would be kept in the asylum while the worst patients including mentally retarded people would be fobbed-off onto cheaper custodial asylums.

There is another issue here which concerns the actual role of the physician in curing the insane. On many occasions Dr. Joseph Workman wrote that the role of the physician was less to prescribe medicine or to practise his peculiar skills, than to act as a firm administrator and friend of the insane. "In truth, the best part of the secret of success, in the treatment of insanity, is found in good beef and a due supply of other nutritious substances."[36] Exactly why a bureaucrat, such as Ferres, should place such stress on the role of the physician in curing the insane, when even the physician concerned realized the truth of the matter, is hard to understand. Part of it certainly had to do with the growing cultural hegemony of the medical profession over caring for the mentally and physically ill. Part of it must also have been due to the fact that Workman was quite

aware, and willing to admit, that those committed as insane suffered from other kinds of problems, such as poor nutrition, while Ferres, from his position as inspector probably found it much more difficult to admit that what was being treated in the lunatic asylum was not always insanity but a range of social problems from old age to malnutrition.[37]

In their annual report for 1864 the inspectors devoted a good deal of space to the problem of overcrowding. With regard to the Beauport Lunatic Asylum, a privately owned asylum near Quebec City in Lower Canada, the inspectors noted that 498 patients were housed in the main building, "a number utterly beyond what that building could properly accommodate."[38] And with regard to the asylums in Upper Canada, they noted that there were 396 patients in the main asylum, and 76 in the university branch. In both cases they observed this constituted dangerous crowding. The inspectors also observed that the amount of sleeping space given to each patient was far below what "the best authorities" considered to be the best average. The result was that the number of deaths had increased about 40 percent from 1863 to 1864, while the level of health of all the inmates had suffered as a result of the overcrowding. And in 1866 the inspectors again compiained about the problems of overcrowding:

> It is truly a most discouraging reflection that after the expenditure of the large sums required to complete the extensive asylums at Toronto and Kingston, we should, at the end of four or five years find ourselves just where we are now; looking round in vain for room to lodge the unhappy claimants for admission into our Asylums, and compelled by force of circumstances to allow many of these unfortunate creatures to linger in our Gaols until their cases have become hopeless.
>
> What is the cause of this choking up of our larger Institutions for the insane? Whence comes it that we are compelled almost invariably to refuse admission to patients whose cases are recent and curable, and only open our doors to admit them when they have become imbecile or hopelessly incurable? Dr. Workman answers.... 'The retention of these incurables is the cause of this evil.' In other words, by retaining our incurables permanently in our Asylums we go on indefinitely multiplying the incurables outside.

In endorsing Workman's proposal for primary and secondary asylums, the inspectors now made it quite clear that mentally retarded people were the prime candidates for the secondary asylums. "Were the two classes of Asylums established," they wrote, "the idiots who in spite of every effort to exclude them crowd our principal Asylums, would find shelter in the Secondary Asylums to the great comfort and benefit of themselves and of the patients in the Primary Institutions."[39]

By this time too, a new justification for housing the incurable insane

and mentally retarded in cheaper, custodial institutions made its appearance. In 1865, the inspectors wrote: "Society or the State may justify, even on the most selfish and economic grounds the expenditure of public moneys in providing buildings and everything else necessary to aid in the work of restoring its insane members to reason. She is thus adding to the number of *workers* and diminishing the number of *non-workers* in the community [their italics]."[40]

Whereas in the past, references to Christian values had often been used to justify public expenditure for asylums, now a different, instrumental argument began to appear, and although arguments based on altruism and religion never entirely disappeared, the authorities increasingly supported their policies in terms of cost/benefit calculations. These instrumental arguments were entirely plausible when applied to the curable insane, because the cost of leaving a person uncured could be shown to exceed the cost of cure. In the case of the incurable insane and retarded, however, the balance sheet showed only debits in the form of permanent and escalating costs. Thus, those who supported expending provincial funds on the incurable insane and retarded tended to rely on arguments based on altruism or Christianity to justify a minimal level of care. Even so, it was difficult to support claims for additional expenditure on mentally retarded people beyond that minimum since no return on "investment" could be expected.

The Educational and Asylum Models of Care

By the time of Confederation in 1867, the Upper Canadian authorities had given up the attempt to bar mentally retarded people from the lunatic asylums, preferring rather to lump them together with the incurably insane in the branch asylums at the University of Toronto, Malden and Orillia. At this time, the lack of an explicit mental retardation policy in Upper Canada was exceptional in comparison to the eastern United States. As early as 1848, Massachusetts, and in 1851, New York State had both established experimental, and later permanent training schools for mentally retarded children. Similar schools were established in Pennsylvania in 1852, in Ohio in 1857 and in Connecticut in 1858. Thus, while many American states were opening schools for the education and training of mentally retarded children, the Upper Canadians were desperately trying to keep mentally retarded people out of the lunatic asylums.

Yet these different policies followed from the decision taken, or in the case of Upper Canada, not taken in the 1840's and 1850's. Although it is always risky to explain policy in terms of the influences of 'great men,' there seems to have been no one in Upper Canada of the stature of either Samuel Gridley Howe or Hervey B. Wilbur to convince the legislature about the desirability of establishing educational institutions for mentally retarded children. It was through Howe's influence that in 1846 Massachusetts appointed a distinguished commission to "inquire into the conditions of the idiots of the Commonwealth to ascertain their numbers and

whether anything can be done in their behalf." Whenthe Commission, headed by Howe, reported on February 26, 1848, they recommended the establishment of a special school for "poor idiots:"[41]

> The benefits to be derived from the establishment of a school for this class of persons...would be very great. Not only would all the idiots who should be received into it be improved in their bodily and mental condition, but all the others in the State and country would be indirectly benefited. The school, if conducted by persons of skill and ability would be a model for others. Valuable information would be disseminated through the country; it would be demonstrated that no idiot need be confined or restrained by force; that the young can be trained for industry, order and self-respect; that they can be redeemed from odious and filthy habits, and there is not one of any age who may not be made more of a man and less of a brute by patience and kindness directed by energy and skill.[42]

Thus, the first training schools for mentally retarded children in Massachusetts, New York and Pennsylvania came about directly because of the influence and efforts of Howe and Wilbur. From the 1840's to the 1860's these schools enjoyed an excellent reputation and met with a wide degree of success. But their success in training, and returning mentally retarded children to the community can be explained by the extremely rigid entrance requirements imposed on candidates for admission. Without exception, these first schools accepted only those mentally retarded children who were educable and who were clearly mildly retarded. In 1852, for example, Howe said of the Massachusetts School for Idiotic and Feeble-Minded Youth: "The institution is not intended for epileptic or insane children, nor for those who are incurably hydrocephalic or paralytic, and any such will not be retained, to the exclusion of the more improvable subjects."[43] Since for a long time these schools were the only available public institutions for the mentally retarded in the U.S., the severely retarded and the adult retarded who were not eligible for admission began to crowd local and county asylums, almshouses and state lunatic asylums. The same process occurred in Upper Canada, except that Dr. Workman was quite lenient in admitting mentally retarded people to the PLA. He knew that there were no alternative institutions available except for the local jails.

From the 1840's to the 1860's, therefore, mental retardation policy conformed to two models in North America: an educational model and an asylum model. The first policy was explicit, that is, schools for certain classes of mentally retarded people were established by the government and their procedures and governance were regulated by statute. The second policy was implicit, that is, institution superintendents as well as local, state, and provincial authorities realized that mentally retarded people did not really fall within the scope of existing lunacy legislation,

but generally allowed them to remain in the various institutions where they were found.

The first model was based on the belief of a few heroic pioneers that mentally retarded people could be educated so as to maintain themselves in the community. There was never any intention, at least at the beginning, that mentally retarded people would remain in these schools on a permanent basis. But the authorities who encountered mentally retarded people elsewhere realized that the jails, almshouses, county, state and provincial lunatic asylums could provide little more than a place of refuge and sustenance for those who could not cope with life in the community, or who would have been maltreated or exploited if left to their own devices.

By the 1860's, however, those jurisdictions following the educational model found themselves being inexorably pushed toward the asylum model. The reasons are not difficult to find. Families with retarded children or relatives could either keep them at home or place them in the available, but miserable, local institutions for the poor, the criminal or the insane. If these families were lucky, their mentally retarded dependents might gain admission to the state or provincial lunatic asylums under the pretence they were insane. But both local institutions and state and provincial institutions were becoming increasingly crowded after the 1840's and 1850's since families as well as local communities were fobbing off not only mentally retarded people, but the old, the destitute, the sick, the delinquent, indeed a whole range of deviant or disadvantaged groups onto whatever public institutions were available. Thus, immense pressure was put on the training schools for the mentally retarded to admit a wider variety of people, including adults as well as severely retarded persons. In these conditions it became increasingly difficult for the schools to maintain their educational role, and they were inexorably pushed toward the asylum model. This forced a re-orientation of policy in jurisdictions such as Massachusetts, New York State and elsewhere where schools had been established, while in Ontario, after 1867 it forced government to make explicit a policy which had been implicit for so many years.

2

The Rise of Orillia

After Confederation in 1867, the province of Ontario inherited not only the Provincial Lunatic Asylum in Toronto and the University, Malden and Orillia branch asylums, but also the jails, reformatories and hospitals of Upper Canada. The province also had to make a decision about the board of inspectors, the key governmental institution in the area of social policy.

The inspectorate had been appointed in 1859 because of the administrative difficulties encountered by the first board of directors of the PLA. Initially, the board had been given the power to appoint the medical superintendent as well as the "Officers and Servants" of the PLA, but this had immediately caused conflict when the medical superintendent and the board clashed over the merits of asylum attendants.[1] By 1853 a new statute had been passed which gave to the medical superintendent the power to "direct and control the medical and moral treatment of the patient — hire and discharge from time to time the Keeper and Servants — watch over the internal management and maintain the discipline and due observance of the By-Laws of the Institution."[2] In addition, the power to appoint the medical superintendent was taken away from the board (two of the physicians appointed as medical superintendents during this time, Doctors Park and Scott were related to members of the board of directors) and vested in the Governor-General. Centralization of authority was strengthened even more with the passage of the 1859 statute: "An Act Respecting Inspectors of Public Asylums, Hospitals, the Provincial Penitentiary of Canada and of all Common Gaols and other Prisons," also referred to as the Prison and Asylum Inspection Act of 1859. This Act provided for the appointment of five inspectors with broad pow-

ers of inspection and administration. The inspectors conceived their role even more broadly than the statute implied, for in their preliminary report they defined their task as, "to have to consider all the questions whether of principle or detail connected with Asylums, Hospitals and Prisons — to be charged with the direction and control of every thing relating to the administration of public charity, and with the execution of the punishments inflicted by justice — to have, moreover, to investigate the causes of the sufferings and crimes which afflict society.... The members of the Board devote all their disposable time to studies bearing upon the duties and rights of society, both as respects the afflicted and the dangerous classes."[3]

Over the next eight years, in reports fifty or sixty pages long, replete with statistics, ruminations about the causes of insanity and crime, and suggestions for future policy, the inspectors undertook an immense and tiring task. Not only did they have to oversee the four lunatic asylums, but two hospitals, "One Large Penitentiary, Two Reformatory Prisons and Fifty-Two Common Gaols" scattered over what is now Ontario and Quebec.[4] The burden was especially hard since the government did not fill one of the posts which fell open in 1864, so that for the latter part of their tenure from 1864 to 1867, the inspectors were under increasing pressure in the performance of their duties.

Despite their declared interest in looking into broader questions of the nature and solution of social problems, the inspectors were quickly overwhelmed by the details of day to day policy. Above all, they became aware that one of the primary determinants of policy today is what policy was yesterday. "In proof of the great difficulty of making radical and beneficial changes," they wrote in their Preliminary Report of 1860, "it is only necessary to glance at what has been done and what is still being done in the old countries of Europe...."[5] Moreover, the first two chairmen of the board of inspectors, Wolfred Nelson from 1860 to 1863, and J.C. Taché from 1863 to 1864 were physicians, and both accepted prevailing ideas on the nature and treatment of insanity and mental retardation. Along with the medical superintendents they criticized the fact that asylums were filling with incurables, thus hindering the early, and, as contemporary theory had it, effective treatment of insanity. As regards mental retardation, their attitude is illustrated by the comments of Dr. Nelson, reporting on a visit to the Lunatic Asylum at Beauport, Quebec, he noted: "I was struck with the great number of inmates whose countenances denoted congenital idiotism and helpless imbecility.... These should manifestly form a class totally distinct from ordinary maniacs. A building of a very simple construction, and under a far more economical regime, would meet all exigencies, while the discipline would be easily carried out."[6] In 1863, James M. Ferres noted that for the lunatic the "asylum is a necessity, for the [idiotic] it is made available as a convenient means of riddance."[7]

If the inspectors were hardly innovative with respect to mental retarda-

tion policy, they did argue strenuously for an expanded and improved system of institutions for the insane. But their influence was limited. Despite their unanimous condemnation of locating a lunatic asylum at Orillia, the government opened an asylum there in 1861. And while the inspectors condemned the system of branch asylums as leading to lax and conflicting administration, and proposed the construction of a smaller number of independent, larger asylums, the government made no move in this direction but rather tinkered with the administration and finances of the existing branch asylums. The inspectors also rejected what they saw as the American dual asylum system, where some asylums were exclusively reserved for the curable insane, or the wealthy, and where the poor, the incurable, "imbeciles and idiots of the poorer classes are sent to the poor-houses in the different counties and treated in the most abominable manner."[8]

The inspectors quite explicitly accepted the fact that Canadian institutions were performing the dual function of hospital for the cure of the insane and asylum for the care of those dependent or disadvantaged groups which had no alternative haven but the asylum. For this reason they threw their weight behind a policy of building new asylums and enlarging the capacity of existing asylums to cope with the intense demand for accommodation.

But placed between a government which was reluctant to spend ever-increasing sums on the asylum system, and a public which clamoured for more space, the board of inspectors complained in 1864: "The Inspectors for their part have to deal with the families who exclaim against the practice of allowing lunatics to wander at large — with the municipal and prison authorities who protest against the sending of the lunatics to the gaols — with political men, who consider the expenditure of the public institutions enormous — and with lunacists of high standing who are unwilling to crowd their asylums. The public may thus judge of the difficulty of the situation."[9]

Although they had a good deal of freedom to give policy advice to the government, the inspectors had little room for manœuver. The result was that like bureaucrats in similar positions everywhere, they looked for ways to economize. They rationalized the accounting system, improved asylum administration, collected detailed statistics on all aspects of asylum policy in Canada, and sought comparative data from the United States and Great Britain. Inevitably, primary consideration was given to the problem of balancing public demand for space against the government's desire to get the best service at the least cost. Unlike the United States where boards of trustees would frequently speak in the interests of the patients, and where they constantly pressured the government and private sources for funds, the Upper Canada asylums were completely integrated into the public sector. There was no one whose sole interest was in the welfare of mentally ill and mentally retarded persons.

Thus, the asylums were always on a tight budget and were constantly

being asked to cut down on expenditures. Moreover, since the inspectors had responsibilities for prisons and hospitals as well as the asylums, it was inevitable that asylum policy would be linked to government policy toward the other public institutions. The fate of mentally ill and mentally retarded persons thus became bound up with government policy toward other disadvantaged groups including the poor, the unemployed and the aged. Of course, policies were never applied in a completely uniform fashion in either an administrative or a temporal sense, but the very presence of an inspectorate at the centre of the welfare net meant that policies attempted in one area would reverberate throughout the whole system. It also meant that no matter how well-intentioned individual inspectors might be, mental health and mental retardation policy would be primarily influenced by the interests of government, rather than by the interests of the residents of the public institutions.

After Confederation, the province of Ontario scrapped the five-man inspectorate and substituted a single inspector under the authority of the Provincial Secretary.[10] Except for some minor changes such as requiring the inspector to visit asylums three instead of four times a year as under the previous statute, the 1868 Act resembled the original 1859 Act.[11] For the post the government chose John Woodburn Langmuir, a man who brought immense reserves of energy and a high degree of skill to the new job. Born in Scotland in 1835, he had emigrated to Canada in 1849. For the next few years he worked in business in Kingston, and Picton, Ontario, and was elected Mayor of Picton at the age of twenty-four. He was appointed inspector on June 26, 1868.

Entering into his new job with gusto, in his first year as inspector, Langmuir visited the Malden Branch Asylum at Amherstburg and noticed that low quality supplies were being purchased at high retail prices. He complained that the "patients' wearing apparel had the appearance of having been purchased for the purpose of assisting merchants to get rid of a lot of worthless and antiquated dry goods at a high price. A case of this trash having just come into the store was ordered to be returned."[12] Obviously Langmuir was not the kind of man to countenance the cozy relationship that often springs up between those who make purchases for government institutions and local merchants.

Two years after taking office Langmuir proposed that a provincial warehouse or depot be established for the storage of supplies to be purchased centrally by the government at the cheapest prices, and then kept for future use. He prodded the bursars of the various asylums to collect fees from patients who had sufficient property or wealth but from whom the asylums had neglected to collect payment.[13] And whereas it had been traditional for the inspectors to audit asylum expenses after the funds had been spent, Langmuir inaugurated a system of pre-audit in 1873 so as to approve expenditures beforehand. Above all, Langmuir made himself the champion of the cheap asylum. Like his predecessors in the inspectorate, Langmuir accepted the necessity for increasing asylum capacity

while at the same time cutting expenses to the bone, but he sought to reconcile these objectives by reducing the capital expenses on asylums to the bare minimum.

By the late 1870's, with the incessant clamour for more funds and more accommodation ringing in the ears of legislators, and with the increasing suspicion that poor, unemployed and mentally ill and retarded persons were somehow responsible for their own fate, as well as causing some of the major social problems of the time, the asylum model was gradually being replaced by a custodial model. Mentally ill and retarded people were no longer going to be protected from society, rather, society was to be protected from them. Given this change in perspective it is no wonder that policy-makers throughout North America now sought to save money at the expense of mentally ill and retarded persons. Langmuir was in the forefront of the struggle to cut down on asylum expenses:

> Of late years, not only very liberal, but very extravagant ideas have prevailed in the construction and fitting up of Insane Asylums, which I am of opinion would be unwise to imitate or continue in this Province.... While it is extremely desirable that Asylums should possess all the comforts of a cheerful, well appointed house, I cannot but think that the expensive, and in some instances extravagant method of construction and elaborate ornamentation that has been adopted in the past, has operated very injuriously against the welfare of insane populations...for I apprehend that so long as Asylum accommodation is made to cost from $1,000 to $1,500 per patient a large proportion of this unfortunate class will have to remain in the hands of their friends, and without Asylum treatment until they become hopeless incurables, for it must be remembered that more than three-fourths of the present population of our Asylums, as well as those now seeking admission to them, are of the indigent or non-paying class, whose condition in life before becoming insane utterly unfits them to appreciate architectural beauty or expensive embellishments....[14]

This view represented a fundamental change from the 1840's. At that time the Upper Canadian elite took pride in the liberality, even extravagance embodied in the monumental structure of the PLA. The construction of a new and modern asylum open to all would not only reflect the Christian benevolence of its founders it would also demonstrate to the world that Toronto and Upper Canada had to be counted among the advanced outposts of modern civilization. Now, in order to save money, Langmuir proposed to close the branch asylums, to construct new, cheap asylums and quickly soak up the accumulated demand for space. Moreover, in justifying this policy, Langmuir's language reveals how much attitudes had changed since the inception of policy in the 1840's. Mentally ill and mentally retarded people were no longer viewed as un-

differentiated objects of pity, rather policy was now to take account of the specific social or class backgrounds of the patients. This comes out quite clearly in 1875 when Langmuir declared himself opposed to "increasing the comforts and luxuries of patients in our Asylums beyond that scale which the average class has been accustomed to enjoy in their own homes, nor am I of the opinion that it would conduce to their permanent recovery to do so."[15] In the United States, ethnic differences also gave rise to remarkably similar comments. In 1851, for example, a Brahmin trustee of the Massachusetts General Hospital suggested that it would be advisable to "build a cheap building or rent one in the vicinity of the hospital where Irish immigrants were treated. They cannot appreciate and do not really want, some of those conveniences which would be deemed essential by most of our native citizens."[16]

Therefore, when the government decided to construct an asylum in the western part of the province in London, Langmuir argued that it could be built at one half the usual cost of $1,000 per bed, that is, at $500. But the London Asylum soon encountered problems because of faulty construction and Joseph Workman was later to sarcastically refer to it in his reports as the "50 per cent asylum."[17]

Since he had administrative authority over all the provincial public institutions, Langmuir was well aware of the fact that people were being shuttled back and forth among the institutions as each tried to reduce its population by fobbing off inmates onto the other. Moreover, it was well-known at the time that mentally retarded people were frequently committed to local jails for petty crimes or vagrancy, and then labelled as "dangerous lunatics" in order to gain admission to PLA. Langmuir estimated that 25 percent of commitments to the PLA were "irregular" and he commented that: "In many instances the Magistrate who commits is ignorant of the first principles of law he is called upon to administer, and quite harmless imbecile vagrants are pronounced and committed as dangerous lunatics."[18]

Langmuir's search for economy finally led him to directly confront the problem of mentally retarded people. Since it was assumed that adult mentally retarded people were incurable and would inevitably become lifelong residents of any institution they were committed to, Langmuir suggested that instead of their taking up asylum beds which could be used for the curable insane, they might be housed separately in cottages built on the grounds of the main asylums. In this way they would alleviate the pressure on the asylum, but because they would be under the supervision of the medical superintendent of a main asylum, they would escape the second-rate treatment that was an endemic characteristic of the dual asylum system as practised in the United States. No more than his predecessors, did Langmuir advocate returning the incurable insane or mentally retarded to existing local institutions:

> It is therefore very apparent that the question of providing increased

Asylum accommodation must be considered concurrently with the question, what are we to do with our chronic insane? The fact that of the 1,489 insane persons occupying beds in our Asylums on the 30th last September, no less than 1,150 were hopelessly incurable is sufficient evidence that the problem of how we can best provide for this class is the most important that can arise in connection with the speciality of Asylum administration.

The humanity and benevolence of the age, it will not be denied, places it beyond doubt that it is as much the duty of Government to provide for the care and comfort of its chronic insane as it is to furnish proper accommodation with all the appliances that modern skill and science has devised, for the treatment of acute cases of insanity. Whether both these objects should be combined in one and the same establishment is a subject for consideration.

The system which, until within a recent period, obtained in the State of New York, in connection with the Utica Asylum by which only what were thought to be curable cases were admitted and patients found to be incurable were discharged from Asylum residence, was eminently favourable to the proper treatment of acute cases of insanity; but quite the reverse in the case of the chronic. The latter class, when discharged from the Asylum were returned to the county from which they came and consigned to the wards of a local poor-house, and to the tender mercies of comparatively irresponsible officials. The abuses and cruelties practised in these local establishments were so great that public opinion compelled the Legislature of the State of New York to provide separate Government Asylums for the custody of her chronic insane.

That it is necessary or even desirable to have separate Institutions for each class has not been fully decided by the members of the specialty.[19]

The Idiot Asylum at London

Thus, as a first step, Langmuir recommended the construction of an Idiot Asylum in a building separate from, but on the grounds of the newly opened London Asylum. The legislature duly appropriated $10,000 and the Asylum for Adult Idiots opened on the grounds of the London Lunatic Asylum on September 1, 1872. By this time, however, asylum policy in the province was utterly confused. While the Ontario authorities universally condemned the American system of separate asylums for the curable and incurable insane, nevertheless, they had begun to follow a de facto dual asylum policy which in practice was barely distinguishable from the American model. In 1869, for example, Henry Landor, medical superintendent of the London Asylum, and a man whose thinking about mentally retarded people had a deep influence on Langmuir wrote: "I am no advocate for the division of insane into a hard and fast line of curables and incurables; one class to be cared for, and treated on liberal and en-

lightened principles, with a view to speedy cure, and the other condemned as hopeless, lodged at a cheaper rate, fed on a more meagre diet and the objects of cheese paring savings.... Is it not so in the county refuges in Ohio and other States and in England also?"[20] Yet, in words that must have been music to Langmuir's ears, Landor suggested that many of the chronic, incurably insane could be housed in cottages built at one half the cost as the London Asylum.[21] It was this kind of argument that had led Langmuir to propose the construction of the Idiot Asylum at London. But as with the "50 percent" main asylum, the Idiot Asylum immediately ran into structural problems. "There are many defects in the structure of this building. No provision was made originally for hot water and the substitution of a boiler inside the building creates a nuisance. There being no chimney to carry off the smoke, a twelve inch iron pipe has been carried into the nine inch kitchen flue. The consequence of this stroke of genius is that the house is filled with smoke every time the boiler fire is lighted and it will not be remedied until a chimney is built."[22] Langmuir had also proposed that the Idiot Asylum at London be the first of a series of branch asylums for idiots to be constructed on the grounds of the main asylums, with a maximum capacity of "seventy idiots which is the greatest number that should be placed in one establishment."[23]

At this time Langmuir was well aware that for decades, mentally retarded children had been trained and educated in schools in the U.S. and in Europe, and he argued quite strenuously that the province should establish a training school:

> The class of idiots for whom it is most desirable that something should be done in this Province are the youths between the ages of 5 and 14. These idiotic and imbecile children of whom there cannot be less than from 200 to 300 in Ontario are now growing up without any training or instruction and are constantly contracting vicious habits, and in many cases dangerous propensities. In every family where they are, their care is attended with the greatest anxiety, but among the poorer classes it is to be feared they are often utterly neglected. So long as this state of things is allowed to exist asylums for adult idiots must continue to be enlarged, and their number increased in order to provide quarters for this unfortunate class. Under these circumstances it becomes a question for the serious consideration of the Government and the Legislature, if a well devised effort should not be made to reduce the number of adult idiots who require to be supported by the public and confined in asylums owing to dangerous habits or indecent behaviour. This can only be accomplished by the establishment of a training school for idiotic and imbecile children. The reports received from such institutions now in operation in Great Britain, and other countries in Europe, as well as in the United States are most satisfactory. Over fifty per cent of the children trained and instructed in them are fitted to be placed

> in families, where they become useful and earn their own living.... When we consider that every adult idiot placed in an Asylum at the age of twenty-two, which is the average age of the present residents of the Idiot Branch of the London Asylum will have to be supported, on an average for twenty years in an Asylum, at a cost of $140 a year, even public economy would suggest the adoption of the only remedy that can be provided — viz., the establishment of a training school.[24]

This argument was to be repeated countless times by Langmuir and by the various medical superintendents and inspectors who followed Langmuir through the years. But Ontario continued to follow the asylum, and later the custodial model. One reason was that existing institutions were already overcrowded with inmates and provincial legislators did not look kindly on establishing a training school which, of necessity, would admit only a small percentage of those clamouring for admittance. But another reason had to do with existing pressures on the policy makers of the time. As Langmuir pointed out, and as Dr. Henry Landor, the medical superintendent of the London Asylum confirmed, the provincial jails were already jammed with large numbers of mentally retarded adults. Moreover, according to Landor many of those who were kept at home "equally required removal from filth and neglect and bad or ignorant treatment."[25]

It is a well established practice among policy-makers to develop policies in a gradual, non-radical, incremental fashion. Examples of new initiatives or sudden or violent changes in policy are rare. Mental retardation policy in Ontario was no exception to this rule. Given the fact that local officials were putting pressure on the provincial authorities to relieve them of the mentally retarded people in jail, it is no wonder that the province barely deviated from the policy of providing more accommodation for retarded adults, rather than switching suddenly toward an educational model. As Dr. Henry Landor pointed out with regard to the Idiot Asylum: "The Idiot Asylum is not intended for the training of imbecile children.... The Asylum is intended to contain only those idiots who have long been in the gaols of the Province of Ontario, or who have been maintained by Townships or retained at the homes of relatives, without any special treatment and too often subjected to most careless and injudicious management, both at their homes and in gaols. No doubt such an institution was urgently needed. The gaols required to be relieved from the presence of such inmates and the inmates require better and cleanlier care than they received in gaols."[26] Langmuir stipulated that admission to the Idiot Asylum at London would go in the first instance to "those who have been committed to the several gaols of the Province as persons dangerous to be at large and who under the Statute cannot be admitted to Asylums for the Insane.... Next to this class the most urgent cases in private families should be awarded admission; dangerous proclivities or vicious habits always being the test of urgency." And Langmuir warned

against laxness in admission policy for otherwise the "beds of the establishment will soon be filled by a class of *quiet, harmless* idiots and imbeciles to the exclusion of proper subjects [his italics]."[27]

Clearly, mental retardation policy in Ontario sprang not from any clearly defined positive policy objectives, but rather out of a set of quite negative considerations: to alleviate pressure for space on local jails and the main asylums, to cut costs, and to improve the therapeutic climate for the curable mentally ill.

But the same litany of complaints of municipalities fobbing off their unwanted poor, insane or retarded people onto the asylum system began immediately with the first report on the Idiot Asylum by the medical superintendent Dr. Henry Landor.

> It would simplify the question of providing accommodation for the future increase of the insane if local houses, whether styled Refuges or Houses of Industry were established in each County or union of Counties. It must be well known to you that there are many feeble, destitute persons utterly unprovided for. The towns and Counties try to get rid of them by sending them to gaol or Asylums. I have been obliged many times to point out to the different authorities that the papers sent for application of admission contain descriptions of either feeble paralytics or harmless imbeciles, become so from disease or evil habits, who are not fit for Asylums but very proper objects for Houses of Refuge.[28]

The following year Landor reported despairingly to Langmuir of instances where commitment certificates had been clearly falsified. "All this shows what little dependence can be placed on statements made with the view of getting rid of troublesome people, and by any means throwing them on the Asylum. No remedy can be had as far as I can see for an inherent want of veracity, where there is an interest in any object to be gained."[29] More seriously still, Langmuir observed that a "large proportion" of the forty-three insane persons confined in provincial jails were "quiet, harmless imbeciles, who doubtless have been committed to Gaol, owing to the trouble and expense their care entailed in private families, rather than to the possession of any dangerous propensities."[30] If Langmuir had been less of an optimist, or perhaps a bit more of a realist, he would have realized how practices of this kind would inevitably undermine any attempt to build sufficient accommodation for the insane and retarded. For as fast as the jails were emptied of the insane and retarded, they were replaced in equal or even greater numbers. As Langmuir himself observed, the demand for accommodation did not come from an increasing rate of insanity among the population, but rather was prompted simply by increasing the amount of available space.[31] But Langmuir did not realize, or perhaps did not want to admit, the full implications of what he was saying for he con-

tinued to argue that asylum policy could be made to succeed through careful regulation of intake, by ensuring that the curable insane were provided with sufficient accommodation and by admitting only the most dangerous or needy of the incurable insane and mentally retarded to the asylum. By the 1870's, therefore, the Ontario government tried to get the municipalities to provide houses of refuge for the incurable insane and retarded, or at a minimum, to set aside separate rooms or accommodation for them in the local jailhouses. But the municipalities were loath to act, while the medical superintendents continued to oppose any suggestions of a system of local care. The result was that Ontario drifted toward a dual system, one fully supported by government where differential levels of care were given to the curable insane on the one hand and the incurable insane and mentally retarded on the other. Langmuir enunciated this policy quite clearly in his 1875 report.

> I have felt it to be my duty...to urge upon the Government and the Legislature the necessity for providing much more extended accommodation for the insane and idiotic. Although the provision already made is large in comparison with our population and resources, yet it has always been below, rather than in advance of, our requirements. Consequently, cases of insanity, which if immediately treated might have been curable, have from lack of room been denied admission to an Asylum; from want of proper treatment have become chronic and incurable; and in many cases have become a life burden upon the State. These people are too late received as patients when all hope of cure is past; and they form an annual residue of life residents who are filling up our Asylums and crippling their curative resources. I have, therefore, recommended the withdrawal of a part of the chronic cases from the larger Asylums, providing for their accommodation in cheaper structures, where their cost to the State will be diminished, and their home comforts increased, and retaining the large proportion of beds in the Main Asylums for curable cases. This, with an Asylum for Idiots, and a Training School for juvenile Idiots, will, I trust, meet the most recognised wants of the community in this respect.[32]

As brief as it was, this was the first time any government official had made an explicit statement about mental retardation policy. Yet in arguing that mentally retarded people should be placed in separate asylums so as to better facilitate the work of curing the insane, and in expressing the hope that a training school would be established, Langmuir touched on two themes of provincial policy that were to prevail until the turn of the century: the care of mentally retarded people was to become separate from and unequal to that given to the insane, and the hopes for a training school were to remain hopes.

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The Idiot Asylum at Orillia

Initially mentally retarded people had been dispersed throughout the asylums, while after 1861 they were increasingly diverted to the Orillia Branch Lunatic Asylum. By 1870, however, the government decided to close Orillia because the building, originally built as a hotel on the shores of Lake Couchiching, had proven unsatisfactory. Many of the patients from Orillia were transferred to the London Asylum and mentally retarded people among them placed in the Idiot Asylum at London in 1872. At this point the province and the government of Canada entered into a lawsuit about the ownership of the building and land at Orillia. The case was finally settled in favour of Ontario in 1873. Given his ideas on mental retardation policy it was logical that Langmuir recommended that Orillia be used specifically as an idiot asylum. In 1876 he wrote: "In consequence of the accumulation of idiotic persons in the Gaols, who were reported as dangerous to be at large, and the large number of the same class for whom custodial lodgement had been asked for from private families, I considered it my duty to bring the matter under the consideration of the Government, recommending that the Orillia buildings be placed in order, and utilized for the purposes of an Asylum for Idiots."[33] The village of Orillia also did some politicking in favour of locating the asylum there, evidently attracted by the possibility that jobs would be available to local residents. The Orillia *Times* observed in 1875: "For idiots our Asylum promises sufficient accommodation for years to come. It stands here ready for occupation almost without need of dollar expenditure. There is no more beautiful site for an establishment of the kind in the world, and it is as healthy as it is beautiful...."[34] There is a good deal of unconscious irony in this appeal, given the later indifference and even occasional hostility expressed by the townspeople of Orillia towards the asylum.

Eventually the government approved Langmuir's suggestion and $29,000 was appropriated to refurbish the building as an asylum for idiots. It was, said Langmuir, "by far the most economical method of relief that could be devised for this unfortunate class."[35] On September 25, 1876, the Asylum for Idiots at Orillia opened under the supervision of Dr. J. McLaren Wallace, but just a year later he was appointed superintendent of the Hamilton Asylum. He was succeeded by Dr. A.H. Beaton who was to remain head of Orillia for thirty-three years, until his retirement on August 1, 1910.

Dr. Alexander Hector Beaton was born in Pickering, Ontario in 1838. In 1862, he entered the Toronto School of Medicine, and having specialized in surgery, graduated from Victoria College in 1864. He practised in Simcoe County for ten years and then was made a coroner in 1873. He was appointed medical superintendent at Orillia in January 1877.

The first residents at Orillia consisted of 35 mentally retarded people transferred from the London Idiot Asylum, all those in custody in the provincial jails together with the "most urgent cases that had been reported

from private houses."[36] By the first year of operation there were 103 residents and 40 vacancies.* By the following year the asylum was filled to capacity and Langmuir noted that mentally retarded people were once again beginning to accumulate in the jails.[37]

From its opening in 1876 the Asylum for Idiots at Orillia grew by leaps and bounds. The space made available through new buildings was never sufficient to keep pace with demand, while the inspector's reports during the latter part of the nineteenth century continue to note the presence of mentally retarded people in the lunatic asylums and jails. Two years after it opened there were only 146 beds available for 155 inmates at Orillia, and in 1879 Langmuir observed that some of the younger boys had to sleep two to a bed.[38] By 1880, A.H. Beaton wrote: "Our accommodation having been entirely exhausted for the past two years, and vacancies only occurring through deaths, our operations and movements have necessarily been few."[39]

In desperation, Langmuir had to open two wards for mentally retarded people at the Hamilton Asylum, admitting twenty-seven in 1879 and thirty-nine in 1880. But by this time all the provincial asylums were jammed to capacity. "Under these circumstances," Langmuir wrote, "it became imperative that the two wards of the Hamilton Asylum, in which about seventy-five idiotic persons were confined, should be relieved of their inmates and devoted to the purpose for which they were originally intended."[40] Luckily, at this time, the old Queen's Hotel in the centre of Orillia was up for sale and the province leased it for three years as a temporary home for the mentally retarded men from Hamilton, plus some additional men from Orillia. In this way a temporary "cottage" for men only was added to the Orillia Asylum in 1881.[41]

But even this tactic did not solve the problem, for Dr. W.T. O'Reilly who at this time succeeded Langmuir as provincial inspector, a year later was having to explain the discrepancy in the official statistics between the 233 patients at Orillia and the 220 beds available by the fact that some of the younger children were again sleeping two to a bed.[42] Still, applications for admission to Orillia continued to mount as well as the numbers of mentally retarded people in jails and in the houses of refuge which some counties had begun to erect. Thirty inmates from Orillia were transferred to Kingston in 1885 to relieve the pressure. In that same year O'Reilly reported that the main building on Lake Couchiching was too old to be repaired properly, while of the Queen's Hotel he wrote: "It is a mere shelter for these people and was taken in an emergency for three years."[43] Finally in 1885, after a good deal of prodding from O'Reilly, the province decided

*The occasional discrepancies between the figures for number of residents in the text, and the figures in the tables exist because the inspector or superintendents frequently referred to the number of residents at the time their reports were written, while the tables are based on year-end figures.

to build an entirely new asylum on a new site on the shore of Lake Simcoe, at Orillia to house 550 mentally retarded people.

Soon after his appointment, Dr. O'Reilly made himself the champion of the cottage system of caring for the insane. "While on my recent tour of inspection of American institutions I gave special attention to the subject of asylum erection and extension, and I believe from what I then learned that the erection of monster asylum buildings has become a thing of the past, and that the asylum of the future will, as at Kankakee and Toledo, be entirely on the so-called cottage plan. That is to say, a central administration building, and a number of comparatively small, detached buildings or wards, which number can be indefinitely extended as occasion warrant, and which will afford a maximum of comfort and efficiency with a minimum of cost."[44] O'Reilly also took a particular interest in mental retardation policy, visiting H.B. Wilbur's New York State Asylum for Idiots on more than one occasion, and supporting A.H. Beaton's pleas for more room at Orillia and for the establishment of a school there. In 1885, Dr. O'Reilly wrote to the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons: "I hope that in two or three years we will be in a position to extend a welcome to our friends from abroad and endeavour in some small degree to show our gratitude for past kindness, and to hear their opinion of our efforts to follow in their footsteps. Our institution when completed is to be a cross between Elwyn and Lincoln, a centre building and wings copied from Lincoln and cottages copied from Elwyn."[45]

The new asylum, opened at Orillia in 1887, consisted of a massive red brick main building and two three-storey brick cottages, built on 150 park-like acres on Lake Simcoe. The main building had space for classrooms on the ground floor, and dormitories and sitting rooms for "the trainable mentally retarded" on the upper floors. The cottages were intended to house those mentally retarded people thought unfit for education or training. Just one year after the new buildings were opened, 284 residents were housed at Orillia. By 1895, Beaton again complained that every bed at Orillia was occupied although "it would be possible to crowd in about 20 more which would bring the population up to 600 — fifty more than these buildings were planned for."[46] In 1897 when the population had reached 637 in residence and 689 in treatment, a room originally intended for use as a hospital had to be set aside for a dormitory.[47] By the turn of the century, there were 654 residents at Orillia, 104 more than the intended capacity. Moreover, the process of fobbing-off had continued. In 1892 Beaton complained that:

> Among the admissions for the year are a few who should be cared for in county poor-houses. Aged persons who maintained themselves as long as they were able to work and now that they have become infirm they are palmed off on the Province to relieve friends and municipalities from their care. Recently an attempt was made

> to send to us three vagrants who have for a number of years been confined in the gaol of one of our largest and richest counties, and whose representatives from year to year persistently oppose the erection of a home for these destitute people. There is no pretence that these people are idiots, but the authorities and physicians are willing to certify that they are imbeciles; and so are a great many more throughout the country through age and want. If we continue to receive vagrants and paupers, it will be necessary to extend the buildings indefinitely. There should be some law to compel penurious municipalities to make provision for the care and support of their poor, instead of committing them to gaol with the hope that they may be ultimately thrown upon the Province for support.[48]

Even before Orillia had opened, the explosion in demand for accommodation had led the various inspectors, beginning with Langmuir, to squeeze asylum budgets as much as possible. In 1879 Langmuir boasted that, "in the asylums of no other country does a more enlightened and humane system of treatment prevail, or is more administrative economy preserved, than in the Asylums of the Province of Ontario." Certainly the "administrative economies" mentioned by Langmuir were astonishing. By 1875, comparisons of the cost per patient per annum of patients in Ontario asylums with patients in various American asylums showed that while the per patient cost at the Toronto Asylum was $129.42 and at London, $131.96, comparable costs at the Massachusetts State Asylum in Northhampton were $190.80, at the Pennsylvania Hospital for the Insane, $246.42 and at the Pennsylvania State Lunatic Asylum, $308.25. Over the years this difference was to be maintained, and in the case of Orillia the per patient rates were to sink to among the lowest in the world. Provincial Treasurer A.M. Ross was able to boast before the legislature that the average per capita expenditure per patient in Ontario asylums in 1883 was almost one half that of the lowest average to be found in the United States, $134.68 in Ontario, versus $227.75 for the U.S. "We find that in the United States the cost per patient is nearly double what it is in our own Province. (Applause.) This fact speaks volumes for the economy with which our Asylums are carried on."[49]

In making comparisons among asylums both within Ontario and between Ontario and the U.S. it is wise to be cautious since circumstances peculiar to the asylum or the region sometimes come into play. For example, in his 1879 report Langmuir pointed out that at the London Asylum it cost almost twice as much for "beer, wine and spirits," i.e. $2.54 per patient per year, as at Toronto, where the expenses were held to $1.43, while at Kingston there was no expenditure on alcohol because of the superintendent's opposition.[50] Moreover, by this time the Ontario Legislature was strongly opposed to the use of alcoholic beverages, although some superintendents defended their use for working patients as well as for medicinal purposes.

In 1878 the cost per patient per year for milk at the Hamilton Asylum was $4.75, at Orillia 66 cents, while no charge appears for Toronto or London. The reason is that Orillia, Toronto and London kept their own cows while other asylums bought milk from local farmers. Frequently differences in expenditure for items such as vegetables or clothing could be explained by whether the particular asylum had had a good crop that year, or whether the inmates in the sewing room had been productive.

On the whole, though, the dramatic economies obtained in Ontario as compared with the American asylums came from paying personnel, both superintendents and staff much less than elsewhere, by having a few staff for many patients, and by feeding the patients a monotonous and tasteless diet.

In 1883, inspector O'Reilly noted that the average monthly wage for attendants in the United States was $73.82 while in Ontario it was $29.32. He acknowledged that: "The advantages the Americans derive from this liberal expenditure is a very great one. They get a much superior class of people for attendants which fact alone contributes largely to the comforts of the patients." He also noted that in the United States the asylums were furnished more expensively with more money spent on books, periodicals, newspapers and amusements.[51] And in 1895 O'Reilly's successor, inspector R. Christie, pointed out that in Ontario the ratio of attendants to patients was 1:14, while in New York State hospitals it was 1:7. He also cited Dr. Thomas S. Kirkbride, a leading American authority on insanity and for forty years the medical superintendent of the Pennsylvania Hospital for the Insane, who stated that the best ratio was one attendant to every eight patients, with a maximum of not more than 1:10. In the same report Christie also cited an article in the *New York Medical Record* of January 26, 1895 calling attention to the fact that in New York State the lowest salary paid to a medical superintendent of an asylum was $4,000 while in Ontario the highest salary (for the superintendent of the Toronto Asylum) was $2,000. This was exactly the same salary as was paid to the provincial inspector. The article also went on to claim, however, that "Ontario has sustained its reputation as the banner province of the Dominion, by excellent provision for the insane of its population."[52]

Maintaining its asylum population at "poor house rates" as A.H. Beaton put it, meant that the inmates led a drab, cheerless existence, increasingly crowded into asylums whose intended capacity was quickly exceeded only a few years after opening. There they were assisted by fewer and fewer attendants, and given food which inspector O'Reilly admitted was "plain and unattractive. There is an absence of variety and style in service, which becomes extremely distasteful to many patients, as they frequently tell me, and which could be much improved if a little increased expenditure were permitted by the Government."[53] Needless to say, not only did the government not increase expenditure, but it kept it as low as possible.

Consistent with the policy of separate but unequal care for the mentally retarded, Orillia suffered even by comparison with the other Ontario asylums, as shown in Table 6. Except for a brief period from 1886 to 1891 when the figures are inflated because some inmates were housed in separate quarters during construction of a new building, the government spent less on Orillia than on the other asylums. By 1892 Orillia's costs had plummeted to a point far below that of any other asylum in Ontario, and, according to A.H. Beaton, to below those of any similar institution in the world.[54] It is possible to estimate the source of these differences by comparing expenditures on an item by item basis. The main problem is that these figures do not take account of products from the asylum farm or dairy, nor of items such as clothing manufactured by the inmates themselves. One item that is significant, however is "butchers' meat, fish, poultry." During the 1880's and 1890's no slaughtering took place at Orillia although meat was obtained from the animals kept by the other asylums. Despite this fact, expenditure for meat at Orillia was consistently lower than for the other asylums. Part of the reason was that there were many children and young adults at Orillia, whereas there were no children at the other asylums. But part of the reason was that the patients at Orillia were given less meat, fish and poultry than those at the other asylums.

In addition, the salaries and wages paid to the attendants at Orillia were lower, on average, than those paid to attendants at the other Ontario asylums. Under the heading "Amusements" exactly $54.21 was spent during 1894 at Orillia compared with $214.50 at Toronto and $428.14 at London.[55] At no time from 1876 on did Orillia ever spend as much on amusements as the other asylums. And Orillia suffered even more by comparison with some American asylums. In 1883, for example, inspector W.T. O'Reilly visited the famous New York State Asylum for Idiots at Syracuse, run by H.D. Wilbur:

> To those who visit Idiot Asylums in the United States it will seem almost incredible that the clean, bright, active and useful people they will see about such institutions can have been developed out of such unpromising material as the untrained idiot class. But such is the work which is being accomplished elsewhere with exactly the same class of people as are to be found idle and useless in Orillia Asylum and such is the work which can be, and I hope soon will be performed here. Common humanity demands at least that the attempt should be made, for anything more utterly dreary and pitiable than the lives ordinarily led by this class of our population could scarcely appeal to human sympathy.[56]

At Orillia the situation was certainly depressing. For years A.H. Beaton chafed under the indifference shown to the asylum by the townspeople, and he complained: "All the interest taken in us is confined to

a few of the business men who are making or expect to make some profit from our custom. Beyond this we are absolutely ignored."[57] The following year Beaton again complained that the town had completely ignored the asylum, although the Church of England choir gave one concert that summer. However no other church choir or organization had visited the asylum.[58] By 1890, Beaton was still contrasting the general indifference of the townspeople with "similar institutions in the United States" which at Christmas time received "little odds and ends" from local businessmen which were highly appreciated by the children.[59]

Keeping Expenses Down

Yet, if conditions were bad at Orillia, they were even worse in those nine Ontario counties where houses of refuge had been erected, and where 16 percent of the inmates were either imbeciles or idiots.[60] For instance, in 1888 the average cost per inmate per year at the York Industrial Home was $57.59 as compared to $158.93 at Orillia. Admittedly salaries were higher at Orillia and expenditure on things such as medicine, stationery, library, advertising and printing were incurred at Orillia but there were also differences in diet. For breakfast at York the inmates received "porridge and milk, bread, syrup, tea and the women get butter and the working men meat." For dinner, "soup four times per week, other days roast meat (fish in lieu sometimes in winter) potatoes, vegetables, bread and tea." For supper, "bread and butter, with either rice, syrup, apple sauce or cheese and tea, with extras for sick inmates at all meals." Special meals were provided at Christmas, New Year's and Easter. There is also a notation that: "All are allowed to eat till satisfied."[61]

At the new Orillia in 1888 breakfast consisted of coffee, bread and butter, porridge four days a week, cold meat for the workers twice a week, corn mush and hash each one day a week. For dinner (lunch), meat, potatoes and bread five days a week, stew potatoes and rice or vegetables two days a week. And for tea (supper) bread, butter, tea and stewed fruit twice a week, hot rolls or currant buns once each a week.

In addition to keeping asylum expenditure low, and Orillia's at the absolute minimum, the inspectors gradually strengthened their hand over the revenue side of the operation. Under the 1839 Act providing for the establishment of the Provincial Lunatic Asylum, provision had been made to ensure that those patients with sufficient funds or their relatives should contribute to their asylum expenses. By 1853 the statute provided that the immediate family — father, mother or Guardian — of a lunatic under the age of twenty-one was liable for his maintenance expenses if they "were able to pay." Over the age of twenty-one the patient was assessed for maintenance costs on the basis of his real or personal property.[62]

One of the problems, however, was the lack of suitable accommodation for "respectable patients" as Joseph Workman put it in 1868.[63] When Langmuir became inspector he ordered that one male and one female ward be set aside for paying patients at the PLA. He also found that the

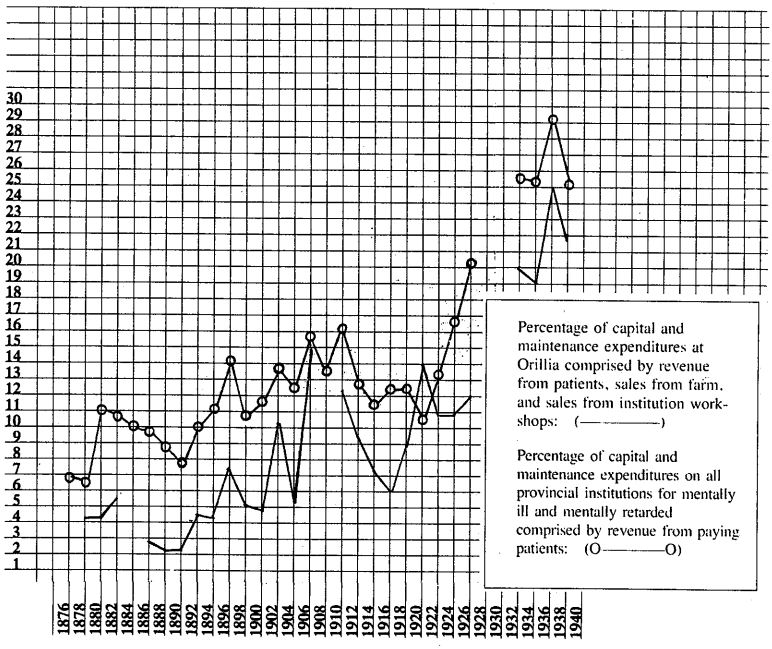
PLA's bursar had been lax in collecting arrears payments from some patients and that in other cases, quarterly payments that had been originally made after the patient first entered the asylum, had stopped soon afterwards. Langmuir prodded the bursar to rectify the situation and was soon complimenting him for his "zeal and energy" in obtaining information about those responsible for maintenance costs and collecting payment. But Langmuir also noted that in some cases people who found themselves in reduced circumstances after committing relatives to the asylums were exempted from further payment and placed on the free list.[64] He further tightened control over paying patients by drafting a series of sixteen by-laws in 1871, among them one stipulating that if a patient had initially been admitted as a free patient (a euphemism for those too poor to meet maintenance costs) but if he were later found to have a "father, mother, guardian, committee or other person legally or morally liable to pay for his or her maintenance," the bursar would then present a bill to the person responsible. These strictures had two results: first, they contributed to the tendency to use the warrant system (described below) to commit patients to the asylums and second, they led to a steady increase in the revenue of the various asylums.

By 1881, the last year of his tenure as inspector, Langmuir had almost doubled the percentage of paying patients at the PLA, from 18 percent to 33 percent while the proportion of maintenance expenses comprised of revenue from these patients rose from 20 percent in 1872 to 30 percent in 1881. In his 1881 report, Langmuir showed that for all asylums, the number of paying patients had risen by 250 percent, from 118 in 1871 to 414 in 1881, and revenue by 192 percent from $14,045 to $41,066.[65] By 1892, the various bursars had become so effective at eliciting payment from patients or their families and relatives, that 38 percent of asylum maintenance expenses (excluding capital expenditures) came from revenue, and by 1902 the figure had reached 41 percent.

At Orillia, however, the story was different, for both the number of paying patients and the amount of revenue derived from them was minimal. In 1877 only .3 percent of the maintenance expenditures were covered by revenue, and only 12 percent of the patients paid for their maintenance expenses. In 1892, the figures were, respectively 5 percent and 9 percent, and in 1904, the figures were exactly the same. The explanation for the low percentages seems to be that those committed to Orillia were poorer on the average than those who were sent to the major lunatic asylums. Barring an analysis of the socio-economic backgrounds of those committed to Orillia and the lunatic asylums, however, this is mere supposition. The fact that a certain number of beds were set aside for the wealthier patients at the PLA whereas this was not the case at Orillia is indirect proof that Orillia was unlikely to attract those who could pay for their expenses. Another factor that must have militated against sending those who could pay to Orillia was the differential treatment accorded to the patients at Orillia as compared to those at Toronto, or, even more

important, with mentally retarded people at the New York State Asylum for Idiots at Syracuse. Once again evidence is lacking, but it is likely that many Canadians who could afford the cost, sent their children or relatives to the New York Asylum where treatment and conditions were so much better than at Orillia.

Table 1: Revenue from Patients and Institution Sales: 1876–1940



In addition to keeping a tight rein on expenditures, ensuring that as many patients as possible paid for their upkeep, pleading with the government and local municipalities to construct alternate institutions such as houses of refuge and trying to prevent the community from fobbing off ineligible people onto the asylums, the various inspectors tried to prod the government into establishing some kind of training school for mentally retarded children at Orillia.

Educating Mentally Retarded People

Initially, as we have seen, the belief that mental retardation was incurable lay behind the early origins of mental retardation policy in Upper Canada. The early Ontario policy-makers seem to have been unaware of the work being done with mentally retarded children in Massachusetts by Samuel Gridley Howe and Edouard Seguin. Having chosen to follow an asylum model in dealing with mentally retarded people, it is understandable that the Ontario government balked at sinking additional funds into a training school. After all, swamped as the institution was with pa-

tients and with demands for admission, committing funds for such a purpose must have seemed like throwing good money after bad. Of course, there were those like Langmuir who supported the idea of a school, especially since they believed that it would save money in the long run. Langmuir was supported in this by Dr. Henry Landor of the London asylum, although Landor stressed humanitarian reasons for establishing a school. Like O'Reilly he was particularly impressed by a visit to the New York State Idiot Asylum at Syracuse where the children had been taught to be clean, the boys to do field work and the girls to sew and knit, where all listened quietly to readings or even read themselves, and where they learned to sing hymns. "I felt much regret and some reproach," he wrote, "when I thought of the ignorance and want of instruction of those poor children under my charge. But it is impossible I can attend to them. I have not a teacher. It is an Asylum for the mere common care and keeping of the inmates and no more. They must in common humanity be removed and taught elsewhere." And as a final warning on the evil effects of mixing mentally retarded adults and children together in the same wards, Landor wrote: "No one inexperienced can conceive of the horrible badness and abominable conversation of a grown up, untaught idiot."[66] Despite these pleas, and the introduction of a bill in the 1870/71 legislature (later withdrawn) nothing was done toward the establishment of a training school, and even the re-opened asylum at Orillia was not provided with any training or education facilities.

However, when Beaton became superintendent there he undertook on his own initiative to train some of the children in elementary lessons in spelling, reading and arithmetic. In addition, a series of physical exercises were taught in the form of climbing ladders or simple calisthenics. At the same time, Beaton pleaded in his annual reports for the legislature to appropriate funds for the establishment of a training school for mentally retarded children. One reason for the legislature's reluctance to accede to Beaton's request may have been due to the fact that Beaton wanted the school established separately from the Orillia Asylum since, he claimed, Orillia needed every inch of farmland surrounding the asylum. In any case, Beaton used every conceivable argument to support his case for a training school for mentally retarded children. He cited the examples of Massachusetts, Pennsylvania and New York State to show that mentally retarded children might be "trained, and in many cases educated." The outcome, Beaton claimed, was that many of them were fit to "take a respectable position in society" or even to be self-supporting. To establish a school, Beaton claimed was "essential in the interests of economy, without taking the higher ground of humanity."
He warned that untrained idiots would not only be helpless, but repulsive and a permanent danger to the community, they would grow up vicious and "unsafe to be at large."[67] In 1884, inspector O'Reilly took up the cause, and expatiated at great length in his report for that year on the desirability of establishing a training school along the lines of the New York

State Asylum for Idiots. Moreover, he suggested that: "If to these motives of humanity is added one which perhaps appeals more directly to the popular mind, namely that of economy, the plea would seem to be unanswerable."[68] In 1887, O'Reilly had taken the initiative of circulating a seven-item questionnaire to American superintendents of asylums for mentally retarded people, specifically asking them about the optimal size of classes for children, about whether it was necessary for the teachers to have teaching certificates and about the number of teachers and class sizes at their own institutions. The superintendents agreed that, depending on the ages of the children, the average size of class should be between fifteen to twenty per teacher, that formal training for teaching was not necessary, but rather that "qualities of the heart and disposition" were more important.[69] That same year, Orillia was given funds to hire two teachers, and classes finally began in May 1887.

Although this was a far cry from establishing a separate training school, at least it was a beginning, and Beaton looked forward to improving the facilities and increasing the number of teachers. But the school at Orillia never really got off the ground. For one thing, Beaton found that teaching the children songs, games and the elementary rules of spelling and arithmetic led nowhere unless there was some kind of follow-up in the form of specialized training in the trades. For as the children got older and progressed through the classes they forgot what they had previously learned. But an even more important reason for the failure of the school at Orillia was the refusal of the provincial government to provide sufficient funds to hire teachers. Beaton constantly complained about large classes and about the need for additional teachers. Ironically, the main building at Orillia begun in 1889, and completed in 1891 had been designed with teaching in mind. Two large gymnasiums and twenty classrooms had been provided, but by the 1890's the government's apparent commitment to educating mentally retarded children had begun to weaken. One reason was the criticism of the Patrons of Industry, an Ontario political movement backed by farmers opposed to the growing influence of urban Toronto, ardently in favour of cutting government expenditures and suspicious of the rising urban elites to the point where doctors and lawyers were excluded from membership. Evidently, the Patrons concentrated their fire on the newly opened school at Orillia. According to Beaton: "While a few of our Patron friends in this vicinity think it a waste of public money, the great number of visitors from all over the province who visit the institution and examine into and watch the process of training are unanimous in their opinion that it is a wise expenditure, and that it is the duty of the state to improve and ameliorate as much as possible the condition of our unfortunate charges."[70]

The high point of the school's existence, therefore, was reached in 1896 when eight teachers were employed, but by 1902 the school had to be discontinued, only to be started up again the following year, but this time with two teachers. Writing in 1908, Beaton commented bitterly

on the period during the 1890's when the exhibit from the school at Orillia had been "ranked among the best in the United States" at the World's Fair in Chicago. But the combined efforts of the Patrons, and an unsympathetic Minister of Public Institutions, had, according to Beaton, wrecked the chances of establishing a permanent school at Orillia.[71]

Under great pressure to reduce asylum expenditures during the last decade of the nineteenth century, the government seems to have constrained the inspector and the medical superintendents to take another look at some system of local care for the chronic insane. There were two reasons for this: first, the government simply could not build enough asylums to keep up with demand and second, there had been public protests against the practice of incarcerating the insane in local jails.

From 1871, when the statutes were revised, a person could be certified as a lunatic (and in addition as an idiot), by "three medical practitioners."[72] Such certification was sufficient for committal to an asylum — if the medical superintendent would admit the patient. However the asylums were so crowded that the medical superintendents often refused to admit new patients. As a result, committal by the warrant system was the preferred method. Here any individual could inform a Justice of the Peace that someone was "or is suspected and believed by the person having such information to be insane and dangerous to be at large" and suspected of being about to commit a crime. The Justice of the Peace could then issue a warrant for the arrest of such a person, commit him to jail and then proceed to a hearing. If the Justice of the Peace were then "satisfied that the prisoner is insane and dangerous to be at large" he was then sent to jail "there to remain until the pleasure of the Lieutenant Governor is known" or until he was discharged.[73] The Lieutenant Governor could then order the person to be sent to an asylum.

The problem was the following. Under the certificate system three doctors had to be paid for examining the person suspected of insanity, while those responsible for the patient had to pay transportation costs to the asylum. Under the warrant system, however, the government assumed all costs. The jail surgeon and an additional physician conducted the examination and the government paid for transportation. The result was that even people who could afford to pay for certification resorted to the warrant system to escape payment altogether. The consequence was that the local jails were perpetually filled with "lunatics dangerous to be at large" awaiting admission to the asylums. Moreover, this latter class was given precedence in admission to those who were under certificate. This is why, from October 1885 to October 1890, 50 percent of the admissions to Ontario asylums had been by the warrant system. By 1890, therefore, inspector R. Christie sent a ten-item questionnaire on their opinions about local treatment for the "chronic insane" to the five medical superintendents of the Ontario asylums. He prefaced it by noting: "As you are aware, in some counties a distinction is made between those that are acute cases requiring special Asylum treatment with a view to their recovery, and those who

are dements, partially imbecile, etc., who also require oversight and care, but would not be benefited by curative treatment. The latter class, in some counties, as you know, are provided for locally by the counties or districts under the municipal authorities." The items that followed asked the medical superintendents' opinions on county and municipal care for the "quieter class of patients."[74]

All five were unanimously opposed to the idea of local institutions for mentally ill and retarded persons. Again, the American example was cited. A.H. Beaton wrote: "In the neighbouring State of New York the system of sending idiots to the poor houses has been fully tried.... It was found that they were not only neglected and allowed to exist in a state of filth and disease, but that many females gave birth to children and in some cases several were the result of illicit intercourse with those appointed to protect them."[75] Beaton proposed instead that the various municipalities from which mentally retarded people came should bear half the cost of their maintenance. And the other medical superintendents answered similarly: the counties would not provide the level of care necessary since they would subordinate everything to the demands of economy; they could not supervise local institutions as effectively as the province; nor could they provide the expertise necessary for proper care. In each case, the superintendents also proposed that while the province continue to care for the mentally ill and retarded, the municipalities be forced to contribute something toward the expense.

With feeble attempts at starting a school finally abandoned, and with the municipalities and provincial policy-makers resisting any attempts at decentralizing policy to the local level, Ontario was heading inexorably away from the asylum model and toward a custodial model of care. By 1900 there were 652 mentally retarded people in residence at Orillia and a waiting list of 336. But Ontario was not alone in crowding an immense number of people into institutions designed for smaller populations. In 1897, at the Pennsylvania Training School for Feeble-Minded Children at Elwyn (capacity 975) there were 1,028 inmates, at the Ohio Institution for Feeble-Minded Youth in Columbus (capacity 800) there were 973 inmates, and at the Iowa Institution for Feeble-Minded Children in Glenwood (capacity 600) there were 690 inmates.[76]

The Policy Palimpsest

What explains the development of mental retardation policy in Ontario from the first negative attempts to bar retarded persons from the Provincial Lunatic Asylum, to the rise of Orillia at the end of the nineteenth century? In recent years a number of explanations of the rise of the large asylum have been advanced. For analytical purposes they can be grouped under the following headings: historical, social control, phenomenological, and bureaucratic-political.

The historical explanation put forward by scholars such as Gerald Grob and David J. Rothman is eclectic, suggesting that the rise of the

asylum was provoked by a variety of factors including increasing population, urbanization, the disappointed hopes of early reformers who had expected to cure the mentally ill and educate retarded persons, and the pressure put on state institutions to admit those for whom families or local authorities could not or would not care.[77] As regards Ontario, Richard B. Splane has suggested that the evolution of social welfare can be understood as a progressive movement whereby the government undertook an increasingly important role in providing social welfare to the public so that, ultimately, such policies covered almost every conceivable malady or misfortune. Splane writes: "This remarkable progress in social welfare was attributable, in the main, to the fact that the prevailing ideas in the province made for receptivity to programmes of social improvement.... When governments of the period were presented with evidence of a social welfare need and with a clearly worked out proposal for meeting it, they were prepared to submit an appropriate measure for its implementation to the provincial legislature. The legislature proved willing to adopt, and the electors of Ontario to support, the rapid pace of social welfare advance that was set during this period."[78]

A social control explanation put forward by, among others, Thomas Szaz suggests that ruling élites including doctors, psychiatrists, bureaucrats and politicians try to stigmatize and label as deviants individuals whose behaviour or life styles differ from the accepted middle class norm. Their reason for doing so is that they fear for their own positions at the top of society if competing viewpoints are given the same legitimacy as those of the middle class. A marxist variation on this argument holds that the ruling bourgeois class supported the rise of big custodial institutions in order to cope with the political threat posed to the existing capitalist order by the burgeoning unemployed, poor and delinquent classes. As Andrew Scull, one of the leading proponents of this view puts it: "The formal commitment to rehabilitation remained, but the practical concerns of those running the system were now far different: the isolation of those marginal elements of the population who could not or would not conform or could not subsist in an industrial, largely laissez-faire society."[79] Finally, there is a phenomenological explanation which links the rise of asylums and the incarceration of deviants to the role of "moral entrepreneurs," frequently medical doctors, psychiatrists or social workers or others who, for various reasons label others as deviants and support efforts toward isolation and institutionalization.[80]

Admittedly most of this literature concerns mental health policy, but the similarities with mental retardation policy during the nineteenth century are broad enough to be included in the analysis.

The difficulty with these explanations is that they ignore the internal tensions and contradictions of policy itself in an attempt to explain the evolution of that policy. Moreover, they tend to take a one dimensional, unilinear perspective, overlooking the fact that mental retardation policy (as well as mental health policy) was composed of a number of disparate

strands all developing at quite different rates during the nineteenth century. That is why the metaphor of a palimpsest is used here.

During the nineteenth century, not one but a series of mental retardation policies were superimposed on one another, with newer policies obscuring, blurring or relegating older policies to minor importance, although never entirely replacing them. Moreover, mental retardation policy meant quite different things to different people during the nineteenth century. State or provincial authorities, local government officials and the public often had contradictory ideas about what policy was and what it was supposed to achieve. It was the continuing tension among these different conceptions and expectations that was at the centre of the process of evolution and it was the weakening or strengthening of different participants in policy that helps explain why one or another aspect of policy in the palimpsest emerged as dominant or vanished into obscurity.

Viewed in a North American context, the policy palimpsest looked like the following. From approximately 1848 to 1875 mental retardation policy was initiated by a small group of humanitarian reformers, mainly doctors but also including a few politicians in Massachusetts, New York, and later, Pennsylvania. Policy was directed specifically toward a very narrow range of mentally retarded people, namely 'teachable idiots' between the ages of six and seventeen. Programs were educational in character and intended to help the child return to his family or community. The first institutions were extremely small, and even the biggest had populations of less than 250. During this period, the government of Upper Canada at first ignored mentally retarded people, and then took notice of them only because as part of the class of the incurable insane they were hindering the attempt to use the asylum to cure the insane.

Sometime in the late 1860's and early 1870's, however, a new policy was gradually superimposed on the previous educational policy. By this time families or friends of retarded people as well as local government authorities all through North America were putting immense pressure on existing institutions, whether they were local almshouses, poorhouses, jails, county lunatic asylums, state or provincial lunatic asylums, or the first schools for retarded people. The schools particularly were under pressure to admit adults, severely retarded and epileptic people — at that time specifically excluded from admission. At first, the institution authorities and even central government officials tried to resist this pressure, but they were eventually forced to give way. However, they were completely unable to deal with the new class of inmates who poured in. The early schools for the feeble-minded in the northeastern U.S. had achieved a remarkable degree of success because they had carefully screened the candidates for admission, ensuring that only the most promising would enter the schools. Now the schools were forced to deal with those who had complex emotional or physical problems. Under these conditions it is no wonder that the schools became asylums, and that their educational functions were relegated to a minor role. In Ontario, this was

not a problem since the Asylum for Idiots at Orillia was originally intended to function as an asylum for all classes of retarded people. Orillia could not lament the loss of a function it never fulfilled. At the same time, however, the authorities in Ontario as elsewhere in North America found that it was extremely difficult to limit admissions even to the broadly defined classes of mentally retarded people who were eligible, for other classes of disadvantaged and dependent people kept turning up in the asylum population. Unwilling to turn these people back to their families or to the rudimentary municipal institutions, the Ontario asylums continued to grow apace.

It is important to emphasize here that between the rise of the early educational institutions of the northeastern U.S. and the rise of the immense custodial warehouses of North America at the end of the nineteenth century, there intervened a period when state and provincial institutions were swollen by inmates who medical superintendents kept on not because of social control motives, but because they knew that a terrible fate would meet those turned back to the community or to local institutions.

The period when institutions functioned primarily as asylums tends to be elided in most accounts of the nineteenth century because it was so brief and because it tends to blur into the custodial period of the late nineteenth century, when social control motives were indeed present. Even David Rothman usually so careful to avoid taking a social control approach implies that the shift toward custodialism occurred because institutional authorities, with the tacit acceptance of the American public, were fearful of certain elements in the population:

> The public accepted the decision [to move toward custodialism]. The inmates were a clear threat to safety and security, and also in many cases they were foreigners, and both considerations heightened the appeal of confinement, no matter how custodial the routine. The community would be spared the danger of their presence through a program that appeared to be especially appropriate for newcomers. A prison sentence would terrorize anyone, regardless of background, training, language, religion or inclinations; the almshouse, despite its deficiencies, could still relieve at minimal cost those who otherwise might starve or beg in the street. The mental hospital was a useful place for locking up lunatics, even without the prospect of cure.

Obviously, there is little difference between this interpretation and a social control approach.[81] Yet, to read the comments of the Ontario policymakers, the medical superintendents and the various inspectors, one gets the impression of men harried by a public intent on committing an inordinate number of people, some eligible, some not, to the provincial lunatic and mental retardation institutions. And although it is true that in 1860 Workman observed scornfully that the local authorities regarded anyone

who had too little to eat as dangerous [see p. 7] he also noted that "the Asylum is known as a good boarding-house." Thus the movement toward the custodial model came about because of a mixture of motives, not the least of which was the desire of families as well as local communities to exchange private costs for public costs. The reason for this is quite obvious: poor people had no alternative but to place the burden of caring for mentally ill or mentally retarded children or relatives on the state. Prior to the rise of public care this burden had been placed on the church, on the local community, or on the family. Not infrequently, the individual was left to fend for himself. But clearly it does not take élite fears of disadvantaged or deviant populations to create a clientele for even the worst public institutions.[82]

Although the Asylum for Idiots in Orillia was gradually moving toward a custodial model, and while this process was occurring throughout North America, the educational model did not entirely disappear, although it temporarily sank to the lowest level on the policy palimpsest. At the immense Pennsylvania Training School for Feeble-Minded Children in Elwyn, from 1853 to 1870 the discharge rate was 50 percent of those admitted each year. By 1885 when the total population was 443, 93 children were admitted and 46 were discharged.[83] In an article on the Massachusetts School for Idiotic and Feeble-Minded Youth, Peter Tylor and Jamil Zainaldin note: "While the data clearly demonstrate the trend toward custodialism...at no time were the members of these custodial groups more than 30 percent of the resident population. For the rest of the pupils the institution continued to function as a short term diagnostic unit or a vocational school."[84] Finally, a survey conducted by the National Conference on Charities in 1897 of twenty-four American institutions for the mentally retarded, Orillia and three English and one Scottish institution found that not all medical superintendents shared the majority opinion of that period favouring lifelong, custodial care for the feeble-minded. The medical superintendents at Lakeville, Connecticut; Frankfort, Kentucky; Vancouver, Washington; Orillia, Ontario; and Larbet, Scotland all opposed "permanent retention of Higher Grades."[85] Moreover, by the end of the century a new policy of establishing special classes for backward children in the ordinary school system had begun in Rhode Island and had spread through the northeastern United States.

In the North American context, therefore, there were four layers of mental retardation policy on the palimpsest. At the lowest and faintest level there continued a policy of educating or training mentally retarded children in the big institutions, while the new policy of establishing special classes was beginning to emerge. At the next level but gradually receding into the background was the asylum model of policy whereby mentally retarded people, as well as others who could pass themselves off as retarded were admitted to big institutions as an alternative to remaining at home, going to local institutions or simply being left to their own devices. Just below the surface was a social welfare policy. And emerging as the dominant pol-

icy was the custodial model of the late nineteenth and early twentieth centuries. Its objective was not to offer sanctuary, or protection as was the case with the asylum model, but to resolve some of the major social problems of the time by incarcerating those people, specifically the feeble-minded, who were thought to be one of the major causes of those problems. Custodialism was specifically intended as a social control device.

The interweaving of these various policy strands was determined by a complex process of interaction among a number of different factors. Doubtless the influence of ideas was extremely important in shaping the policy context. Prevailing sentiments of humanitarianism, Christianity and altruism certainly played a role in the early days of policy. At the same time ideas about the nature and implications of insanity and mental retardation also affected policy. These ideas were trans-national in nature. There was a constant interchange of ideas among Canadian, American, British and French authorities. In Canada, Joseph Workman published in and reviewed books for the *American Journal of Insanity,* which was established in 1844, and A.H. Beaton was a member of, and in 1884-1885, President of the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons founded in 1876. Although policy in Upper Canada and later Ontario was certainly influenced by specifically Canadian factors (the method of financing for example, and the early establishment of an inspectorate) the general movement of policy was pretty much the same throughout North America. Indeed, there is a sense in which prevailing ideas about policy were a major factor in determining policy at any given point in time. A striking example of this process in action come from the *Journal of Psycho-Asthenics* in 1902. One of the editorial writers observed that the State of New Hampshire had just established a school for the care and education of idiots and the feeble-minded, but only for those between the ages of three and twenty-one. The editorialist was critical of this move since it was obviously in contradiction with the then prevailing mood of custodialism. "Evidently the institution created is to be distinctively of an educational character. While the act does not go far enough in providing for the feeble-minded and makes no apparent attempt at relieving the county almshouses and asylums of their adult or custodial cases, yet it is a step in the right direction."[86] The State of New Hampshire seems to have got the message because in 1905 legislation was passed extending "indefinitely" the limit for the detention of feeble-minded girls.

Another determining factor was the nature of the bureaucracy which shaped and regulated policy. One can pretty well omit the influence of political parties, pressure groups or politicians in Ontario until the end of the nineteenth century since mental retardation policy was a matter of little importance except to those actively involved in the policy process. But this was certainly not true of the inspectorate prior to 1867, nor of the various inspectors after that time. However, with the establishment of Orillia, a dual process seems to have taken place. At one and the same time the bureaucracy was increasing its control over the internal aspects of mental retardation policy, while losing control over its external aspects. Beginning with Langmuir, the

bureaucracy vastly improved the internal efficiency of the asylum, ensuring that Ontario asylums and Orillia in particular would be among the cheapest and most efficient in North America. There was not a single facet of asylum policy that Langmuir or his successors did not investigate or attempt to rationalize in their search for efficiency. In this they were aided by the fact that, unlike the United States asylums, Ontario asylums were not encumbered with boards of trustees or any other semi-independent boards or bodies that might provide alternate policy advice to the government. Indeed, in Cleveland in 1880 Langmuir boasted about the uniform structure of the Ontario bureaucracy in a speech to the National Conference of Charities and Corrections:

> It is hardly necessary to point out that such extensive powers...would not be conferred upon any official without a direct check and partial control being exercised over him by the Government conferring the authority, and this is very simply but most effectively furnished. One of the members of the Ontario Government is the executive head of the Inspector's department [the Provincial Secretary] and with him the Inspector is in constant communication, consulting with and advising him respecting all matters pertaining to the institution service. The Cabinet Minister is of necessity a member of the Legislature of the Province. He is, therefore, both as a Cabinet Minister and as a member of the Legislature, together with his colleagues in the Government, directly responsible to the people for the proper administration of the affairs of the institutions referred to.[87]

But the bureaucracy was not in complete control of all aspects of mental retardation policy for the medical superintendents and inspectors frequently gave the impression of being overwhelmed by the unanticipated consequences of their policies. Despite their best efforts the major problem of demand for space outstripping supply remained and even worsened during the latter part of the nineteenth century. Moreover, there seemed no way to prevent families and municipalities from sending people to the asylums who were clearly neither mentally ill, nor mentally retarded. The reason was that not everyone understood policy in the same way. The inspectors and the medical superintendents conceived of the lunatic asylums as fulfilling the dual role of curing the curable, and providing care and protection for the incurable insane. Orillia was regarded as literally providing asylum for people who simply could not survive or function in the community. But families, local communities and even some doctors looked at the lunatic asylums and at Orillia in a different way. For them the institutions served an undifferentiated social service or social welfare function, that is, the institutions could be used to sustain a whole array of people, many of whom were neither insane nor mentally retarded but who were having difficulty getting along in the community. Whereas the medical superintendents and the inspectors conceived of the institutions as basically a last resort, others saw in them the only available public institutions, aside from jails, for the poor, senile, unemployed, delinquent,

criminal or bizarre. Nor were these different conceptions attributable to ignorance, or bad faith or élite manipulation of the masses, for the popular conception of hospitals and asylums as undifferentiated welfare institutions had deep roots in history. The earliest hospitals, or hospices, linked as they were with churches and monastaries accepted and mixed together all kinds of people; "the aged, infirm, dying, diseased, wounded, blind, crippled, idiot, insane, orphans, paupers, wanderers and pilgrims."[88]

According to Charles E. Rosenberg: "Until the middle third of the [nineteenth] century, specific diagnosis and indeed the very concept of most ills being differentiated in terms of a specific cause and course and characterized by specific lesions was atypical in the medical profession. Holistic definitions of sickness as a total state of the organism were consistent with social definitions of need and dependency; both were inclusive and anti-reductionist and emphasized the continuing interaction between organism and external environment."[89] It was only after the 1850's that medicine began to conceive of illness in terms of specific disease states rather than in terms of the patient's general condition, and the hospital to be used for surgery and recovery from operations, rather than as a rest and recuperation centre. Only gradually, therefore, did the notion of the hospital as a social welfare institution begin to disappear from the public mind. But this was not the case with the institutions. In Ontario, the medical superintendents implicitly accepted the institution's social welfare function by refusing to return those who were clearly neither mentally ill nor retarded to their families or communities.

It is true that many people were labelled as mentally retarded who were nothing of the kind. But it is equally true that the people who did the labelling did not always do so from bad motives. One has to remember that the lesser of two evils might have been admittance to an institution rather than being left to one's fate in the community. For those who were severely or profoundly retarded, for example, remaining in a family that was unable and unequipped to care for the person or commitment to the local jail might mean physical abuse, starvation or at best eking out a miserable existence to the end of one's days. Getting admitted to Orillia, therefore, could mean the difference between life and death. Of course, it is true that some families and communities saw in the creation of large institutions a convenient method of getting rid of troublesome or dependent people. But without a careful examination of the evidence there is no way to determine a priori exactly what percentage of those labelled as idiots or lunatics benefited thereby, or were worse off than if they had remained outside the institution.

Thus at the heart of the mental retardation policy lay a basic contradiction between the manifest and latent functions of policy. On the surface it was intended to serve only a limited clientele of mentally retarded people, while in fact, policy was being used by a wide variety of people to fulfill a social welfare function which, by its very nature, was unlimited in scope and clientele. By the very end of the nineteenth century, however, changing conceptions of the nature and implications of mental retardation were to put the custodial model squarely at the top of the policy palimpsest, where it was to dominate for the next twenty-five years.

Part II

1900 to 1945

3

The Myth of the Menace of the Feeble-Minded — England

From 1841 to the end of the nineteenth century mental retardation policy in Ontario was under the exclusive jurisdiction of the inspectors, the Provincial Secretary and the medical superintendent of Orillia. Neither political parties, pressure groups, ordinary legislators nor even the press had very much influence on policy. However, ideas about policy were widely shared by authorities in Canada, the U.S. and Great Britain. Thus, when the myth of the "menace of the feeble-minded" made its appearance near the end of the nineteenth century, mental retardation policy makers in various countries were immediately alerted to the problem and to its implications.

The myth of the menace of the feeble-minded derived from British and American studies which suggested that feeble-mindedness was inherited, that feeble-minded women had more children than women of normal intelligence, and that, as a class, the feeble-minded were disproportionately represented among the social problem groups of the time: criminals, delinquents, the poor, the unemployed and, especially prostitutes.

In the United States, Richard Dugdale's 1877 study of the infamous Jukes family had been interpreted as demonstrating that poverty and delinquency were inherited in the same way as biological traits.[1] One of the leading experts on mental retardation, H.H. Goddard of the Vineland Training School, had added his considerable weight to the hereditist thesis, while, in 1904, Martin W. Barr, Chief Physician of the Pennsylvania Training School for Feeble-Minded Children at Elwyn had put forward strong hereditist arguments in the first comprehensive textbook on mental retardation since Edouard Seguin. Barr noted:

> The remarkable history of "the Jukes" compiled by Richard Dugdale, shows the gathering forces of varied neuroses when fos-

> tered by heredity and environment through more than a hundred years. Here 1,200 persons, the descendents of five degenerate sisters, repeat in successive generations the tale of disease, insanity, idiocy and crime, reversion to original type or its escape through early death. In these we have surely found evidence in support of the theory advanced, that the transmission of imbecility is at once the most insidious and the most aggressive of degenerative forces; attacking alike the physical, mental and moral nature, enfeebling the judgement and will, while exaggerating the sexual impulses and the perpetuation of an evil growth, a growth too often parasitic; ready to unite with any neurosis it may encounter, and from its very sluggishness and inertia refusing to be shaken off, lying latent it may be, but sure to reappear, as Haller recounts, through a century to the fourth and fifth generation.[2]

This kind of argument formed the ideological backbone of the custodial movement. Based on a doctrine which linked theories on the etiology and nature of mental retardation to social problems and thence to the correct methods of prevention or amelioration, the movement was composed of specialized organizations, mainly pressure groups or professional associations. The movement attempted to diffuse its ideas to the public through all available means such as newspapers, public meetings, articles in popular and learned journals, and to influence policy through formal and informal contacts with bureaucrats and politicians.

It was this movement that plucked mental retardation from the obscurity where it had languished for half a century, and made it, temporarily at least, a major point of controversy and debate.

The background to the growth of the movement has to be sought first in the work of Dugdale, Goddard and others in the U.S., but more particularly in the work of Francis Galton and Karl Pearson in England. Since 1869, Galton had been publishing work on the inheritance of ability, while his student and acolyte, Karl Pearson had been developing sophisticated statistical techniques intended to provide a scientific basis for the study of social phenomena. Although Galton had initially been interested in the question of the inheritance of ability, or "genius" as he liked to call it, near the end of his career he was drawn to the study of the inheritance of lack of ability, or mental retardation. His work and the work of those who followed him seemed to confirm the initial findings: human ability was inherited. While these scientific studies were taking place both in the U.S. and Great Britain various charitable, social welfare and social scientific bodies were accumulating evidence on the extent and nature of the major social problems of the time. Increasingly, social investigators began to establish a linkage between these social problems and mental retardation. By the end of the nineteenth century it was generally accepted that feeble-mindedness was one of the major causes of contemporary social problems.

Because the sequence of events in Great Britain was very similar to, and had enormous influence on the subsequent evolution of mental retardation policy in Ontario, it is important to explain exactly what happened.

The best time to begin is in 1876 when Sir Charles Trevelyan, a member of the Council of the Charity Organization Society, in a motion before that organization in 1876 said that "feeble-minded children ought not to be associated with adult idiots."[3] By "feeble-minded" Sir Charles meant those who had been previously labelled "improvable idiots," that is, mental defectives who had responded to institutional care and treatment to the point where they were able to take care of their physical needs, to learn the rudiments of a simple occupation and, in some cases, to return to the community to find work.

The introduction of the term feeble-minded established an additional grade in the vocabulary of mental deficiency, placing the feeble-minded person just below normal, but above idiots or imbeciles who were considered to be in the lower ranges of intelligence. Over the years, there had been great difficulty in distinguishing between the different grades of mental deficiency. Part of the problem was that idiots and imbeciles were defined in terms of physical stigmata. However, by the end of the nineteenth century observers felt a new term was needed to describe those people who manifested behavioural traits similar to idiots or imbeciles but lacked the characteristic stigmata.

The problem of distinguishing among the various levels of mental deficiency had become particularly acute as a result of the passage of the Education Act of 1870 which had established a national elementary school system and had swept large numbers of children from the lower classes into the schools. It soon became evident that many of these children were suffering from a variety of physical and/or mental problems which prevented them from working well in school. In 1885, the Royal Commission on the Blind, the Deaf and Dumb and Afflicted Classes found large numbers of children who were unable to cope with school because of mental deficiency. As a result, the Charity Organization Society, which had been instrumental in bringing about the appointment of the Royal Commission, organized a special committee to investigate "the number and condition of feeble-minded or semi-imbecile children or adults."[4] Composed of members from organizations such as the British Medical Association, the National Vigilance Association, the Metropolitan Association for Befriending Young Servants, the Ladies Samaritan Society and from various public and private asylums and institutions, the investigators looked at 50,000 school children from the London area. Of these, 9,186 "presented visible defects, showed abnormal nerves or other signs, or were reported mentally dull by the teachers."[5] The investigators then arranged these 9,186 children into fifteen separate categories including those who evidenced "squints...not ophthalmia"; the deaf and partially deaf; those who were crippled, paralyzed, maimed or deformed; children

who were feeble-minded, and those who "required special care and training," and who evidenced a combination of problems such as feeble-mindedness, epilepsy, low nutrition, etc. The investigators then made specific suggestions for the care and education of the children suffering from feeble-mindedness. These included recommendations that special auxiliary day classes partly supported by government grants be established, that the children of destitute parents needing special education be maintained out of taxes and that, in the case of the adult feeble-minded, "small homes" partially supported by payments from school authorities of the Poor Law Guardians be established.[6]

Why did the COS interest itself in this question? In the main, social reformers were disturbed by the number of children who found it difficult to cope with school and especially by children manifesting mental and physical defects who "are all probable social failures — now at the child-stage." It was reported that the feeble-minded children were often neglected in the schools. "They are not being educated at all. It is not possible in Board schools to give them the special education they require. All the teachers can do, in most cases, is to keep them occupied or to teach them some simple occupation."[7]

The last years of the century saw the publication of the results of the COS investigation, the appointment of a Departmental Committee on Defective and Epileptic Children and, in 1899, the passage of The Elementary Education (Defective and Epileptic Children) Act. The latter provided permissive legislation for the establishment by local school authorities of special classes or schools for children "incapable of receiving proper benefits from the instruction in the ordinary public elementary schools, but...not incapable by reason of such defect of receiving benefit from instruction in such special classes or schools as are in this Act mentioned."[8]

Thus, the inception of mass education was one of the major factors leading to the reconceptualization of mental deficiency as a social rather than a private problem.

Since schools are organized along bureaucratic lines, they share certain characteristics with all bureaucracies such as an hierarchical distribution of roles, classification of individuals according to the roles they perform in the organization and assessment of individual performance according to achievement. In the early history of mass education a certain percentage of the children in the schools proved unable to cope with schoolwork. Some were found to have physical ailments or handicaps, but others clearly lacked the requisite intelligence. Thus, the search for an explanation for poor performance led to the development of the concept of feeble-mindedness. In turn, special classes or special schools for mentally retarded children arose soon after the establishment of a modern school system. The first such classes were established in Germany, followed quickly by Great Britain and the United States. In each case the establishment of special classes or schools was aimed at improving the

efficiency of the school system by withdrawing slow students from the classroom. At the same time the assemblage of mentally retarded children in special classes necessarily forced the government to elaborate some kind of educational policy specifically directed toward them.

As the term "feeble-mindedness" took hold, and the concept of feeble-mindedness was increasingly applied to people with a variety of social problems, a connection was rapidly established between the major social problem of the nineteenth century, poverty, and feeble-mindedness. For example, in his study of nineteenth century London, Gareth Stedman Jones has observed that the growing numbers of casual poor in the urban centres and their apparent imperviousness to the rising economy led the urban middle-classes to conceive of this particular group as a residuum, as the lower reaches of the enormous and variegated pauper class. In particular, Jones points out, the view developed that the casual poor constituted a race apart, that "generations which had been born and nurtured in such conditions (of urban life) would inevitably 'degenerate' both physically and morally."[9]

In this view, beneath the class of the self-respecting poor there was another group whose poverty was due "not to the conditions of casual employment but to their 'feeble and tainted' constitutions, the produce of generations of decaying slum life." The use of the word "feeble" is important here since contemporary observers often used it to characterize the weak, the sickly and the unfit who would not survive if the state did not come to their aid at every crisis. Alfred Marshall, for example, commented on the fact that the unfit felt no responsibility toward the society that saved them from losing out in the struggle for survival. "There are no feeble people in the prairies. Some feeble people go there, but they either get back quickly to a large town or else they die...persons in any rank of life who are not in good physical and mental health have no moral right to have children."[10]

During the waning years of the century, therefore, people began to link the existence of the unfit with the newly discovered social problem of feeble-mindedness. Gradually the realization began to dawn that medical science might have discovered in the phenomenon of feeble-mindedness an explanation for some of the major social problems of the time. This explains why a number of voluntary organizations concerned with mental deficiency began to ask the government to appoint a Royal Commission to investigate the true extent and implications of the social problem of feeble-mindedness. Thus, in 1898, at a meeting of the National Association for the Care of the Feeble-Minded, formed three years earlier at the instigation of, and with participation from many members of the Charity Organization Society, Lord Herschell moved a resolution affirming that: "The existence of large classes of feeble-minded persons is a danger to the moral and physical welfare of society and calls for immediate attention both on the part of public authorities and charitable enterprise."[11] At the same meeting, Sir James Kay-Shuttleworth, M.P., also moved a

resolution that the question of the feeble-minded called for parliamentary legislation. By 1903, the interest of Herbert Asquith, Home Secretary (1892-94), and later to become Prime Minister (1908-15), had been aroused to the point where, at a meeting of the National Association, he seconded a resolution asking for the appointment of a Royal Commission to investigate the question of mental deficiency.[12]

The Royal Commission on the Care and Control of the Feeble-Minded, 1904-1908

The Royal Commission on the Care and Control of the Feeble-Minded was appointed in 1904 and reported in 1908. Some of the members of the Royal Commission had previous experience or interest in the study of mental deficiency. C.S. Loch was the secretary of the Charity Organization Society; Ellen Pinsent had been active in establishing special schools for the mentally defective in Birmingham and was a leader of the National Association for the Care of the Feeble-Minded; Frederick Needham was a Commissioner in Lunacy, President of the Medico-Psychological Association of Great Britain and Ireland and later to become Commissioner on the Board of Control established to supervise the 1913 Mental Deficiency Act; Willoughby H. Dickinson, M.P., was Chairman of the National Association for the Care of the Feeble-Minded; Harold N. Burden was the Manager of Certified Inebriate Reformatories, and Horatio Donkin a Commissioner under the Prisons Act.

One of the first tasks the Commission set for itself was to define the various grades of mental deficiency. This proved difficult since some witnesses found it almost impossible to give any definition at all of feeble-mindedness. Thus, when E. Brayn, Medical Superintendent of the State Criminal Lunatic Asylum at Broadmoor, was asked if he were prepared to give any definition of "what constitutes such weakness of mind as to necessitate a person being taken care of," he replied: "I do not think it is possible to give a definition that would cover all the cases...each case must be tried by itself."[13]

It soon became clear that there were wide varieties of interpretation as to what mental deficiency, and particularly feeble-mindedness, was. Although most witnesses agreed that the grades of mental deficiency from idiocy on down could be defined in terms of physical stigmata, feeble-mindedness could not; thus the Royal Commission was forced to look for an acceptable social definition of the term. This came in the form of a series of characterizations put forward by the Royal College of Physicians which were eventually accepted as working definitions. The various grades of mental deficiency were tentatively defined as follows:

> Idiot is here taken to mean a person so deeply defective in mind from birth or from an early age, that he is unable to guard himself from common physical dangers, such as prevent us from leaving young children alone. Imbecile is taken to mean a person who is capable

> of guarding himself against such common physical dangers; but who is incapable, by reason of mental defect existing from birth or from an early age, of earning his own living. Feeble-minded is taken to mean a person who is capable of earning a living under favourable circumstances, but is incapable from mental defect existing from birth or from an early age (a) of competing on equal terms with his normal fellows; or (b) of managing himself and his affairs with ordinary prudence. Defective applies to children only and is taken to mean children who are "defective" as defined in the Elementary Education (Defective and Epileptic Children) Act, 1899.[14].

The ambiguity in these definitions is illustrated by the testimony of Mary Dendy, an early worker in the area of mental deficiency in Manchester, and a founder of the Lancashire and Cheshire Society for the Permanent Care of the Feeble-Minded. She stated that: "The first test [for mental deficiency] I think is that if a woman comes into the workhouse with an illegitimate child it should be considered evidence of weakness of mind; there is certainly evidence of lack of moral fibre."[15]

At first, the Royal Commission sent its two chief medical investigators, Doctors A.F. Tredgold and W.A. Potts to sixteen typical rural and urban districts in England and Wales to determine the numbers and grades of mental defectives in the inebriate homes, lunatic asylums, prisons, schools and workhouses, as well as to estimate the numbers of mental defectives who were not institutionalized, but of whom the authorities were aware. Their findings became the basis on which the Royal Commission made its recommendations, and they were later to be used as evidence in the debate over mental deficiency that followed.

The investigators found that 10,925 persons, or .46 percent of the population in the sample districts could be labelled as mental defectives. Certified lunatics were omitted from their calculations. On the basis of the figures from the sample districts, the Royal Commission then extrapolated to estimate the total number of mental defectives, and the numbers in various institutions for all of England and Wales.

Thus, when the percentage of .46 was applied to England and Wales, the number of mental defectives (excluding certified lunatics) was estimated to be 149,628. Of that number, the Commission estimated that 44.45 percent were "unquestionably in need of provision either (1) in their own interest or (2) for public safety." When the number of certified lunatics was added to the number of mental defectives, the total estimate for England and Wales for all defectives was 271,607 or .83 percent of the population. Most of the defectives were found in institutions. Sixty percent of the inmates of inebriate reformatories were mental defectives; 18.19 percent of those in workhouses; 10.05 percent of those in local prisons; 2.31 percent of those on outdoor relief; .79 percent of children in elementary schools and .18 percent under no authority. In absolute numbers, however, most mental defectives, 54,000, were found to be

paupers, with 47,515 school children ascertained as defective, 45,000 under no authority and 582 defectives in the inebriate reformatories.[16]

The accuracy of these findings is open to question. A.F. Tredgold said he found some teachers who thought that the term mental deficiency referred to idiocy or imbecility, while others thought it referred to physical defect. Still others who realized what it meant preferred not to call a child defective for fear of "offending the parents by stigmatising the children as 'not all there'."[17] And although it is clear that the investigators often found it difficult to distinguish social failure from feeble-mindedness, it is equally clear the two were not thought to be equivalent. For example, both chief medical investigators, Doctors Potts and Tredgold, agreed that only about 10 percent of tramps could be defined as mentally defective. All the medical investigators agreed that roughly one-fifth of the inmates of the workhouses could be classified as mentally defective. Although they did not go so far as to claim that workhouse inmates were simply unfortunate victims of the vagaries of the economy, neither did they label as either sick or immoral all those who wound up in the workhouse.

For example, Dr. Melland, the medical investigator for the Manchester region, attempted to differentiate among the various inmates in the Poor Law Institutions:

> The fact of the matter is that the total of inmates in the workhouses . . . is greatly swollen by the drift of a large number of unskilled workers into Manchester, who as they become older, and less able to get work or retain it, must necessarily tend to spend more and more of their time in the workhouse. I was much surprised to find the number of fairly sober and respectable labourers, who had been forced, as their value in the labour market rapidly declined, to take refuge in the workhouse . . . it struck me that the majority, though I made no exact estimate, were there as a result of old age and through no fault of their own, beyond a certain lack of forethought and lack of provision for ill-health or oncoming age, and some even might be absolved from that.[18]

Even A.F. Tredgold, who later argued that "the feeble-minded and their relations form a very considerable proportion, if not the whole, of the social failures — the degenerates of a nation," stated that only about one-fifth of the workhouse population fell within the scope of the Royal Commission.[19] Tredgold also suggested that the remaining four-fifths were composed of old men and women, of able-bodied people temporarily disabled by accident or illness and "of persons who are practically destitute in consequence of their inability to get work."[20]

Not only did the Royal Commission try to distinguish as best it could between those who were social failures because of feeble-mindedness and those who were social failures for other reasons, it also implicitly distinguished among three apparently overlapping, but really quite dis-

tinct categories of the feeble-minded: children, women and adult males.[21]

Feeble-Minded Women and Custodialism

If there was one group which preoccupied the social reformers and the Royal Commission it was feeble-minded women. It was generally assumed that mental defect was inherited, and, equally important, that feeble-minded women were more fecund than normal women. Above all, mentally deficient women were thought to lack the moral restraints concerning sexual intercourse possessed by normal women. As a consequence, they often became pregnant and brought large numbers of illegitimate and mentally deficient children into the world. Since feeble-minded women were found in workhouses, jails, etc., and since they often became pregnant in or out of the institutions, the ratepayers were forced to pay for the costs of confinement, and often, for the subsequent upkeep of mother and children.

The social problem of mentally deficient women, therefore, was complex and had serious ramifications. Not only were they seen as the biological source of mental deficiency, they also posed a deep threat to existing middle-class and respectable working class notions of sexuality and familial morality. This explains the near hysteria which characterized discussions about the social problem of mentally defective women. In the hearings of the Royal Commission, in the literature of the time, and during the debates in Parliament over the Mental Deficiency Act, case after case is cited of feeble-minded women bearing large numbers of illegitimate, feeble-minded children, who, in turn, bred more feeble-minded children.

The mere recital of the statistics on birthrates and illegitimacy was part of this litany. Thus, A.F. Tredgold, reporting to the Royal Commission on the birth statistics of nineteen feeble-minded women in various institutions, and of forty-two mothers of illegitimate children said:

> The 19 mothers have had in all 80 children. Of these, 16 died in infancy, 19 are imbecile or feeble-minded and are included in my returns, 20 are either physically delicate to a pronounced degree or are mentally dull and backward, and eight are too young to make a satisfactory examination. There are only 17 of the total eighty who to all appearances come up to the average standard of mental and bodily health. With regard to *illegitimate children* [his italics], the 42 mothers have given birth to 78 children. Of these 24 died in infancy, five are imbecile or feeble-minded and included in my returns, two are decidedly dull and backward, two appear to be normal, and of the remaining 45 no information can be obtained. I think, however, that although details are lacking of such a large number one may justifiably conclude that children of feeble-minded women born out of wedlock are not likely to possess any advantages

over those born of married women. Further comment upon this question is needless.[22]

Tredgold then concluded that while the average number of children born to normal parents was four, the average number of children born to degenerate families was 7.3.[23] The Royal Commission accepted these findings and concluded that "the number of children born to mentally defective parents is abnormally high."[24] The *Times* endorsed this view: "Especially in view of the evidence concerning fertility, the prevention of mentally defective persons from becoming parents would tend largely to diminish the number of such persons in the population...the evidence strongly supports measures...for placing mentally defective persons in institutions where they will be employed and detained...and kept under effectual supervision so long as necessary."[25]

Since feeble-mindedness was defined in terms of amorality, social policy had to substitute something in place of the absent restraining influence of morals. The solution advocated was compulsory institutionalization and segregation by sex. In one sense, therefore, the mental retardation reformers of the early twentieth century shared with the Poor Law reformers of 1834 the common assumption that a major social problem was caused principally by moral weakness and that the cure was to substitute legislation and institutions for morals. But the parallel is not exact, for the policy-makers generally regarded feeble-mindedness and its attendant effects as incurable while those who made the 1834 Poor Law assumed that stringent measures, if they might not cure the poor of their moral failings, would at least serve as an example, a warning, and a lesson to others. In the case of the feeble-minded, however, their amorality could not be cured by education, exhortation or example since it was rooted in an irremediable biological condition. The only cure was to stamp out the disease altogether.

The Eugenics Movement

During the years following the appointment of the Royal Commission an energetic campaign was conducted by the *Times* and by various pressure groups, especially the Eugenics Education Society, to get the government to pass mental deficiency legislation. One cannot overestimate the influence of the eugenics movement here, for the work of Sir Francis Galton on the inheritance of ability, the growing fear of physical and moral deterioration of the English race and the work of the Royal Commission all combined to spread eugenic ideas among the English political élite. This culminated in the formation of the Eugenics Education Society in 1907. Among its members during the early years, the EES counted a cross-section of the English intellectual, political and social élites. The Sixth Annual Report of the EES in June, 1914, lists "the Rt. Hon. A.H. Balfour, P.C." as an honorary member, while Havelock Ellis and Dean W.R. Inge were members of the Council of the Society, and included among the ordinary members were people such as Patrick Geddes, Lady

Ottoline Morrell and Arnold White. The eugenists as they called themselves, put forward a number of arguments which soon became the main justifications for mental retardation legislation. These arguments emphasized the relationship between feeble-mindedness and a whole array of contemporary social problems (e.g., poverty, crime, alcoholism, juvenile crime, unemployment, and prostitution), and assumed three important facts about the etiology of feeble-mindedness: that it was hereditary, that it resulted from breeding among the feeble-minded themselves, and that there was a differential fertility rate in favour of feeble-minded women. The solution that offered itself to eugenists and others was obvious: stop the feeble-minded from breeding. The extent to which these ideas had entered into the conventional wisdom of the period is illustrated in the *Times* of November 7, 1910, where the editorialist cited an article in the *Eugenics Review* in suggesting that there was a "definite race of chronic paupers,...breeding in and through successive generations," one which was recruited only partially from among the unskilled or from "the sufferers by the ordinary fluctuations of industry or employment." Moreover, even Beatrice Webb's famous Minority Report of the Poor Law Commission linked the existence of large numbers of feeble-minded to pauperism. In 1909, for example, the Minority Report stated that "in the United Kingdom the mentally deficient number in all their grades more than one-sixth the entire pauper host — an army approaching 200,000 in number constantly receiving maintenance from the rates, in respect nominally of their destitution, but really...by reason of their infirmity."[26] They also argued approvingly that withdrawing the feeble-minded from the workhouses and placing them in special institutions would mean the break-up of the Poor Law system.

By 1910, the *Times* incorporated the findings of the two Royal Commissions into its suggestions for dealing with social problems. It admitted that large numbers of people were in the workhouses through no fault of their own but because they were unskilled or because they were victims of the vagaries of the economy.[27] But, at the same time, the *Times* leapt at the Report of the Royal Commission on the Feeble-Minded since for the first time it seemed to provide a scientific etiology for at least some social failures. In addition to the usual explanations for social failure such as an unstable economy or personal immorality, mental deficiency was now added to the list. Of the three, immorality and mental deficiency were the easiest to remedy. For the first, one suggested education or, if that failed, punishment; for mental deficiency, the Royal Commission's findings indicated that all one had to do was to prevent defectives, in the words of the *Times*, from "reproducing their kind."

The Report of the Royal Commission on the Care and Control of the Feeble-Minded was followed by a five-year campaign for legislation led by two of the most powerful pressure groups in the field, the National Association for the Care of the Feeble-Minded, and the Eugenics Education Society. The establishment of the Eugenics Education Society was

a direct result of the work of the Royal Commission since some of the Commission's leading members felt it imperative to get the government to pass legislation based on its recommendations. For example, A.F. Tredgold and R. Langdon Down, both active in EES, had been medical consultants to the Royal Commission, while Sir James Crichton-Browne, President of the EES from 1908 to 1909, had testified before the Royal Commission as an expert witness.

By 1910, the two organizations had formed a Joint Committee to support legislation. This Committee sent letters to all candidates for the General Election of December, 1910, asking: "Would you undertake to support measures that tend to discourage parenthood on the part of the feeble-minded and other degenerate types?" The response was uneven, but the two groups were far from disheartened.[28]

During the period prior to 1913 both groups demonstrated they had access to the highest levels of the government. For example, in October, 1909, Dean Inge and C.S. Loch, from the EES, met with the Home Secretary, W.H. Gladstone, to urge legislation along the lines of the Royal Commission Report; on July 16, 1910, a deputation from the National Association for the Care of the Feeble-Minded met with Prime Minister Asquith, the Lord Chancellor, Home Secretary Winston Churchill, and the President of the Local Government Board. The editorialist of the *Eugenics Review* noted that Churchill "recalled the fact that there were at least 120,000 feeble-minded persons at large in our midst who deserved 'all that could be done for them by a Christian and scientific civilization now that they were in the world,' but who should, if possible, be 'segregated under proper conditions so that their curse died with them and was not transmitted to future generations'."[29] In June, 1910, delegates of the Council of the Eugenics Education Society met with "30 or 40" members of Parliament to discuss the problem of the feeble-minded. In the face of continued government inaction on legislation, however, two private members' bills were submitted in cooperation with the two associations. By the May 1912, session of the House, the government introduced its own bill which, after a number of amendments, passed Parliament on July 19, 1913, by a vote of 180 to 3. The Act went into effect on April 1, 1914.

The Debate over the 1913 Mental Deficiency Act

Eugenic assumptions about the hereditary nature of feeble-mindedness and its relation to other social problems, the abnormally high birth-rate among feeble-minded women, and the "threat" posed to society by the increasing numbers of feeble-minded women clearly underlay the different versions of the 1913 Mental Deficiency Act. For example, in discussing his Feeble-Minded Persons Control Bill, submitted in the 1912 session of Parliament, Gershom Stewart said:

> What we advocate is that these persons [mental defectives] should

be segregated in homes and colonies, especially the women during the childbearing period....

They [mental defectives] are paupers in the making from the very cradle, and, when the females get to a certain age, they are, I am sorry to say, exploited to a very considerable extent by unscrupulous men to their own undoing and to the great increase of youthful depravity in both sexes. Half the girls in our rescue homes are feeble-minded and of 15,000 births that take place annually in our workhouses a very great number come under the same category.[30]

In a debate over Stewart's bill, A. Lyttelton returned time and again to this point: "These women have no control over themselves. In the summer months when they go out they are a source of temptation, and they are the prey of dissolute minded men. They transmit loathsome diseases throughout the country, and year after year, they reappear in the winter in the workhouses and give birth to children begotten by parents, from time to time who are unsound."[31]

One M.P. who was chairman of the special schools subcommittee of the London County Council said: "I think enough has been said to show that the greatest danger is, of course, with the girls who are mentally deficient. But it is not only the girls.... There are just as many boys, if not more, who want proper care and control." And, at a later stage of the debate over the government bill, one member moved to add a new paragraph to the list of those "subject to be dealt with" by the Act, "(e) sexually feeble-minded persons, that is to say, female persons who do not belong to any of the above-mentioned classes of mentally defective persons, but who are feeble-minded and on account of their mental condition fail to exercise due self-control or due self-protection with respect to sexual immorality."[32] The amendment was defeated.

The leading opponent of legislation for the feeble-minded was Josiah Wedgwood, the Radical MP from Newcastle-under-Lyme. He decried the legislation as the work of "eugenic cranks" and was particularly critical of the attack on feeble-minded women. "If you are merely going to take a degree of variation from the normal as a sufficient cause of putting men or women — because this Bill is principally applied to women — (Hon. Members: "No") well, every argument brought forward has dealt with those unfortunate women who go into our workhouses to have children and so on, and the main argument has been against women and against poor women only. I say it's wrong."[33]

However, the debate over legislation demonstrated how difficult it is to draw neat lines between the eugenists on the one hand and humanitarians on the other. After all, at the beginning of this century people were no more certain of the best policy to follow for mentally retarded people than they are now, and it was possible to argue for compulsory institutionalization from what seems to be the best of motives. For example, Alfred Lyttelton pointed out that one of the major problems was that

feeble-minded people were already to be found in prisons, workhouses and inebriate homes. "I ought to mention that in the last four years, 1,110 cases have been dealt with by the Society for Prevention of Cruelty among Children which has been found to be referable to the parentage of feeble-minded persons and the consequent neglect and cruelty to the children."[34]

One MP, Leslie Scott, produced a series of petitions to the House from "working men and women" supporting the 1913 bill. For example, a member of the Manchester and Salford District Trades Labour Council said of the opposition to legislation: "Our experience, as leaders, has been that the quarter from which the opposition would come is not the quarter where the child is happy. The economic condition of their homes is such that the parents hold fast to these children because they see the possibility of putting them to work even at the sacrifice of the child. They look forward to the time when the children will reach the age of twelve, thirteen or fourteen, and when they can put them out to make money out of them."[35]

And, although he bitterly opposed the compulsory aspect of the legislation, even Wedgwood admitted that "this Bill has behind it the very best efforts of the best-intentioned people in this country not so much inside this House as outside it. They have seen this terrible evil and know how awful it is, and already in rescue homes they are doing what they can to save those poor and feeble-minded persons."[36]

As the debate wore on and as the Government finally introduced its own bill, however, Wedgwood found himself increasingly isolated in opposition, so that when the final vote came, only he and two allies voted against the final version. Inevitably, the Government bill was a somewhat watered down version of the initial proposals, although the key provision allowing for compulsory institutionalization of certified mental defectives was retained. Changed, however, was the definition of feeble-mindedness. The 1913 Act defined four categories of mental defective: idiots, imbeciles, feeble-minded and moral imbecile. The latter two were new categories in English legislation, the first two terms having been incorporated into laws dating back to the fourteenth century. The feeble-minded were defined as: "Persons in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision and control for their own protection or for the protection of others, or, in the case of children, that they by reason of such defectiveness appear to be permanently incapable of receiving proper benefit from the instruction in ordinary schools."[37]

The Act defined the various categories of defectives who "were subject to be dealt with," that is, who could be institutionalized by the State. These consisted mainly of defectives who came to the attention of authorities because they were already in prisons, lunatic asylums, workhouses, reformatories, etc., or were picked up in the street "without visible means of support," were habitual drunkards, or who were "in receipt

of poor relief at the time of giving birth to an illegitimate child or when pregnant of such child." This latter provision illustrates how the government hoped to solve both the problems of lax morality and feeble-mindedness among women at the same time. If it was permissible for feeble-minded women to bear legitimate children while on poor relief, the bearing of illegitimate children rendered the feeble-minded mother liable to compulsory institutionalization and segregation by sex in a mental deficiency institution. The taxpayers were not to be asked to subsidize illegitimacy in the case of feeble-minded women.

Other provisions of the Act stated that the order that a defective be sent to an institution or placed under guardianship was to expire at the end of one year, and then at the end of five-year intervals, unless the Board of Control established to supervise the Act directed that institutionalization be continued. A series of provisions regulated the rights and obligations of Local Authorities in the establishment and funding of special institutions for mental defectives, and the procedures to be followed in the event of derogations from the Act. The Act also changed the existing laws relating to one having "unlawful and carnal knowledge" of a defective woman. Now the accused would have to prove he did not know and had no reason to suspect the woman was defective. Previously, under the Criminal Law Amendment Act of 1885, it was up to the Crown to prove that the man knew at the time of the offence that the woman was an idiot or imbecile.[38]

4

The Myth of the Menace of the Feeble-Minded — Ontario

In Ontario the sequence of events was remarkably similar to, and greatly influenced by what had happened in England. The schools turned up a number of children who could not cope with the system; questions were raised about the presence of mentally deficient children in the schools; specialized pressure groups were formed which began to discuss and publicize the problem of feeble-mindedness in cooperation with social welfare and social reform groups; petitions were signed and representations were made to government officials and finally, in 1917 a one-man Royal Commission was appointed which eventually laid a report on feeble-mindedness before the government. At this point, however, there was one major departure from the British model for, unlike Great Britain, no major legislation dealing with the feeble-minded emerged after the long years of agitation or from the report of the Ontario Royal Commission.

The development of the custodial movement in Ontario began in 1894 when James L. Hughes, an Inspector of Public Schools for Toronto went to London, England to visit some of the special schools for backward children established as a result of the 1899 Education Act. Upon his return to Toronto, he and the Chairman of the Toronto Public Schools tried to ascertain the exact number of mentally deficient children in the Toronto schools. Since only twenty were found there seemed to be no case for establishing special classes in Toronto.[1] However, at the annual meeting of the National Council of Women in 1896 a Mrs. Tilley observed that there were many girls in Toronto who were neither insane nor idiotic, but who were "simple, being unable to take care of themselves and who consequently became the mothers of illegitimate children." She was asked to

make further inquiries, and her report at the 1897 meeting of the NCW led to the establishment of a standing committee on feeble-minded women.[2] That same year Dr. A.M. Rosebrugh, the Ontario Secretary of the National Conference of Charities and Corrections wrote to the NCW asking them to inquire into the "number of unmarried women in each Province under forty years of age who are either idiotic, semi-imbecile, weak-minded or who from any cause are incapable when at large of taking care of themselves." The NCW found a total of 1,235 such women in Canada, 900 of whom were in Ontario.

From that point on the movement gathered momentum. In 1899 the Annual Meeting of the NCW authorized local councils in Canada to petition their provincial legislatures to make provision for the custodial care of feeble-minded women. In Ontario, in October 1902, Mrs. Willoughby Cummins, Secretary of the NCW, and Mrs. Evans, Chairman of the standing committee on feeble-minded women received the approval of Ontario's Premier Sir George Ross and the Provincial Secretary J.S. Stratton to visit institutions for the care of the feeble-minded in Rome and Syracuse, New York, and Newark, New Jersey.[3]

One of the reasons the Premier asked Mrs. Cummins and Mrs. Evans to visit the U.S. was because they "realized the possible legal difficulties that might arise from the commitment to an institution for Custodial care until the age of forty of women who were not insane." On visiting the State Home for the Feeble-Minded in Newark, New Jersey they were surprised to find that there were neither walls nor fences around the various houses which composed the institution. When Mrs. Cummins asked the Superintendent's wife, Mrs. Winspear, how the women were kept in, she learned that: "It is never a question of how to keep them in, they are so happy, but the heart breaking time is when we have to send them away when the age limit is reached." From this Mrs. Cummins concluded: "This was perfectly true, for here in most cases they were really happy for the first time in their lives. They are with their peers, no longer objects of ridicule or dislike or something to be ashamed of or treated unkindly as is too often the case even in their own home."[4]

Here we see the humanitarian aspect of the custodial case. The notion that the retarded person needs to be protected against the vicissitudes and cruelties of the outside world goes back to the very beginning of mental retardation policy and was the central justification for the asylum model of care for the period from 1860 to 1890. But humanitarianism was only a minor strand in the custodial model, indeed it could not have formed the core of the custodial argument since it would have been difficult to justify compulsory incarceration of feeble-minded women merely because of the suffering they underwent in society. Yet the two women from the NCW were not being disingenuous or manipulative in putting the case for protective care in this way. It is one of the ironies of the movement for custodial care that its arguments at this time were a bizarre combination of humanitarianism, prudery, vengeance, desire for social

control, and, particularly on the part of women's organizations like the NCW, a desire to improve the condition of women at home and at work. The NCW, in particular, was in the forefront of social reform during this time, as can be illustrated by the fact that by 1913 it had established committees on topics as diverse as: "Laws for the better protection of women and Children; Supression of pernicious reading matter; care of the Feeble-minded; Immigration; Equal Moral Standards; Education; and Public Health."[5]

Evidently Mrs. Cummins and Mrs. Evans were impressed enough by what they saw during their visit to present a report to the Premier, the Provincial Secretary and to the annual meeting of the NCW urging the government to provide for the custodial care of feeble-minded women between the ages of fifteen and forty-five. On May 20, 1903, a deputation from the NCW, the Prisoner's Aid Association, the Associated Charities and other organizations presented a petition from the "citizens of the Province of Ontario" urging the government to undertake the custodial care of feeble-minded women. Whatever sympathies the Liberal Ross Government might have had, they were unable to act since in February 1905, the Conservative Whitney Government took office. Soon after, however, because of the efforts of the various pressure groups involved, the Whitney Government was made aware that the British Royal Commission on the Care and Control of the Feeble-Minded had sent five of its members to the U.S. to inspect and report on institutions for the feeble-minded. Since the members had no authority to visit Canada during this trip, the Provincial Secretary, W.J. Hanna, appointed Dr. Helen MacMurchy to meet with them for three days in New York City.

Dr. Helen MacMurchy, Inspector of the Feeble-Minded

Dr. Helen MacMurchy (1862-1953) was to play an extremely important role in the history of mental retardation policy from 1905 until 1920 when she was appointed to take charge of the Federal Government's Division of Child Welfare. She was educated at the Women's Medical College of the University of Toronto and at Johns Hopkins Medical School, receiving her M.D. in 1901. She then entered general practice and lectured at the Women's Medical College in Toronto. In 1905 on the urging of Mrs. Cummins she was appointed by Premier J.P. Whitney to conduct a census of the feeble-minded in Ontario. From that point on her reports on the feeble-minded appeared in the Ontario Sessional Papers. Initially she held an untitled appointment but in 1914 she was appointed Inspector of the Feeble-Minded, and her title was placed under the heading "Inspection, Public Institutions" along with the Inspectors of Hospitals and Charities and the Inspector of Asylums and Prisons. It is interesting to note that at no time was her salary equal to those of the male inspectors in the same department.[6] In 1915 she was appointed to inspect the auxiliary classes within the Department of Education. Thus, for the period from 1915 to 1920 she was both an Inspector of the

Feeble-Minded and Inspector of Auxiliary Classes.[7] Dr. MacMurchy was especially active in the National Council of Women and was one of the founders of the Provincial Association for the Care of the Feeble-Minded [p. 73]. Through her voluminous reports as Inspector of the Feeble-Minded, and her wide ranging activities in the movement, she was the very exemplar of the "moral entrepreneur" that Howard Becker describes. MacMurchy was a "rule creator" or "moral crusader" since she was dissatisfied with the existing system for dealing with mental retardation, and deeply committed to a radical change in the rules as regarded the feeble-minded. According to Becker, the rule creator "feels that nothing can be right in the world until rules are made to correct it. He operates with an absolute ethic; what he sees is truly and totally evil with no qualification. Any means is justified to do away with it. The crusader is fervent and righteous, often self-righteous."[8]

Certainly MacMurchy wrote and behaved as if she were conducting a crusade. Her reports in the Ontario Sessional Papers are remarkable not only for their length, often running to thirty or forty pages, but also because of the use of the technique of yellow journalism. The paragraphs are very short, often no more than two or three sentences long, and they are always headed with a brief and dramatic description of the subject. MacMurchy realized that murders, beatings, incest, or other unusual events involving mentally retarded persons would have a greater impact on the reader than the usual litany of facts and statistics that characterized most government reports. In her Sixth Report as Inspector of the Feeble-Minded, for example, the following paragraph headings appear on the first three pages: "Public Opinion Urgent; What Delayed This Report; Hard Cash; What Will Ontario Say to This?; A Toronto Girl the Victim; Unfit for Publication; Ominous for Ontario; What Has Happened?; Supreme Folly; A Poor Policy for Ontario," and "The Price of Delay." MacMurchy's skill as a journalist (she was editor of the *Canadian Nurse Magazine*, and wrote widely for the professional and popular press) is illustrated by the use of subheadings such as "Unfit for Publication" which was then followed by: "It is their evidence that is unfit for publication. *The uncle admitted that he was responsible for the girl's condition*....[her italics]." This technique is still used today, and it is remarkable to see it practised and so skillfully in the service of the custodial movement in 1912.[9]

From her first report in 1906 MacMurchy attempted to cover every conceivable aspect of the question of the feeble-minded. Above all she emphasized the case for custodial care. In the 1906 report, for example, she summarized the results of her conversations with the members of the British Royal Commission visiting New York. She observed that the "general opinion expressed is that the number of feeble-minded in Great Britain is probably as great as the number of insane — not less than 100,000."[10] There is a certain confusion here since MacMurchy is not clear about what she means by "feeble-minded." In the U.S. it was fre-

quently used as a generic term to refer to all mentally retarded people, whereas in Great Britain it referred to the level of mental retardation above idiocy. Moreover, MacMurchy accepted the notion that the numbers of mentally retarded people could be estimated by assuming a 1:1 ratio with the numbers of insane. Since the causes of mental illness and mental retardation were known to be quite different, there was little reason to make this assumption — unless she wished to imply some mutual causation between lunacy and feeble-mindedness. As will become clear below, this assumption may have some basis in fact.

MacMurchy's other conclusions followed the findings of the British Royal Commission: the number of mental defectives was increasing; existing institutions were not appropriate for the feeble-minded since they had been established for a different and lower grade of mental retardation; feeble-minded women had a higher birth rate than normal women; special classes should be established for the feeble-minded in the regular school system; custodial institutions should be established for the feeble-minded found in the regular school system; special custodial institutions should be established for feeble-minded women; it was possible to "ascertain the cause of many, if not of all cases of mental defect" and to use this knowledge to reduce it; "feeble-mindedness goes hand-in-hand with moral and physical weakness;" and an immediate census of the feeble-minded was necessary in Ontario. Moreover, MacMurchy claimed that: "Home care is unsuitable for, at any rate, the majority of these cases, and special boarding-schools are urgently required in the interests of the individual, the family and the nation."[11]

Among the causes of feeble-mindedness MacMurchy listed, "deficient nutrition in the early years of life...the employment of married women at the childbearing period in factories, the marriage of relatives, e.g., cousins; extreme age or extreme youth of the parents, a hereditary tendency to tuberculosis, chronic alcoholism in one or both parents, and descent from a feeble-minded, criminal or insane anscestry." Finally MacMurchy quoted one of the British Commissioners who told her: "Ontario has an opportunity to make a fresh start in dealing with this evil before it has grown too great to cope with it satisfactorily."

In taking a census of the feeble-minded in 1905, MacMurchy sent letters to "officers of those associations who had already petitioned the Government" and to municipal officials, the police, jail superintendents and superintendents of asylums, hospitals, charities, Children's Aid societies, and to a whole series of private and public welfare organizations." In all, 3,000 letters were mailed. The letter was rather confused for it read, in part: "My Dear----, The Government of Ontario has received numerous petitions and requests for better provision for the care and control of the feeble-minded in this Province who have not been certified to as insane or idiots, and yet are not able to protect themselves. Imbecility and heredity are known to be the most prolific of the causes of pauperism, and crime. It has been determined to undertake a complete

enumeration of such feeble-minded persons...."[12] Not only did the letter draw no clear distinction between feeble-mindedness and imbecility, it lumped imbecility and heredity together as "causes" of social problems. Moreover, if the respondent had not already drawn the correct conclusion by linking social problems with feeble-mindedness, the letter drew the conclusion for him. In this way MacMurchy helped to create the social problem whose task it was hers to solve.

As a result of her first census she received the names and addresses of 1,385 feeble-minded persons, 850 females and 535 males. She admitted that the preponderance of women was due to the initial emphasis on determining the number of feeble-minded women, and later surveys did in fact produce almost equal numbers of men and women.

Certainly the emphasis on the dangers of feeble-minded women was related to the middle-class reformers' distaste for and condemnation of those whose sexual mores were different from their own. In addition, there was a clear class bias here since the feeble-minded were assumed to be found among the working classes, among the poor, unemployed and deprived. Of course the social reformers of the time were also motivated by genuine if condescending feelings of pity and sympathy, particularly for women whom they felt were being cruelly victimized by others. What strikes the contemporary observer is the strident moral condemnation of illegitimacy among feeble-minded women and its use as proof of the necessity of custodial care. But it should be remembered that in advocating permanent custodial care for feeble-minded women, the social reformers were not advocating something new or radical, for large numbers of people who had committed no crime were already institutionalized in Ontario's asylums, houses of refuge and houses of industry. Moreover, custodialism was defended on two grounds: it would provide protection and care for those in custody (this was the humanitarian strand to the argument), and it would protect society from the person in custody (this was the social control aspect of the argument). As the *Globe* put it in an editorial on May 20, 1903: "The care of the mentally defective is among the imperative necessities of organised society, and it is a duty which this Province has always faithfully discharged."

But one of the major problems for the reformers was to justify including the feeble-minded within the same law as lunatics and idiots, for only in this way could they be subject to permanent care. As Dr. MacMurchy admitted: "The feeble-minded are difficult to define but not difficult to recognize. They are below those of normal, though small intellect but above actual imbeciles and idiots. They are able to act and may speak fairly well, though usually more or less foolishly. They can partly or even wholly earn their living under supervision, but they are not capable of protecting and taking care of themselves in the world at large. They lack prudence and self-control. They have no proper will or judgment. Hence we find them in maternity hospitals, refuges, gaols and poorhouses."[13] Obviously, the line between social failure and feeble-mindedness was

very thin indeed and in practice the two often merged into each other. But even within the existing committal system there was scope for the feeble-minded if they were seen to fit the criteria.

The Establishment of the Custodial Movement

At the beginning of the twentieth century there were a number of ways a person could be committed to asylums. For committal to Orillia two methods were available, the first through a medical certificate signed by two physicians affirming insanity as well as idiocy. The certificate read: "I certify that the said A.B. is insane and is a proper person to be confined in any Asylum for the Insane (and that the said A.B. is an idiot if such be the fact)...."[14] The second method was through the warrant system whereby a person adjudged insane by the courts could be transferred to an asylum by the Lieutenant Governor. It was also possible to certify as insane and idiotic a person who had committed no crime but who was "suspected and believed...to be insane and dangerous to be at large." He could be brought before a Justice of the Peace and then certified as insane by two physicians.[15]

Of course, the major question is how the physicians determined whether or not a person was insane. Evidently the criteria were quite broad for in 1880, J.W. Langmuir observed that it would be sufficient for a certificate to state that though neither curable nor positively dangerous, a lunatic "is possessed of such habits and practices as unfit him or her for living in the family relation."[16] And the constant complaints from the various asylum superintendents and the inspectors that the aged, infirm, or poor were often certified as insane to get them out of municipal institutions, indicates that some physicians gave a broad interpretation to the term insanity. A schedule attached to the 1877 "Act Respecting Lunatic Asylums and the Custody of Insane Persons" lists questions to be asked about the prisoner. These include questions about the presence and substance of delusions, suicidal or dangerous tendencies, the presence of epilepsy or paralysis, the family history of the prisoner, the "habits of the prisoner as to temperance, industry and general conduct, and in what manner they have changed — whether such change has been gradual or sudden" and whether the patient was "idiotic, imbecile or incurable."[17]

Since the social reformers of the time conceived of the feeble-minded as a class different from, and at a higher level of intelligence than imbeciles and idiots, and since existing laws permitted the institutionalization only of idiots and lunatics, the task of the reformers in the custodial movement was to somehow prove that the feeble-minded should be as eligible under the law for institutionalization as idiots and lunatics. One way would have been to insert the term "feeble-minded" into the relevant statutes, but to do this it had to be demonstrated that the feeble-minded were as irresponsible in their actions as idiots or as dangerous to the community as lunatics.

This was a difficult task given the admitted fact that feeble-minded people verged on normalcy. But what better evidence could there be of the danger they constituted to the community than the high illegitimacy rate among feeble-minded women? By linking feeble-mindedness with major social problems, and by linking the dangers of lunacy to the dangers of feeble-mindedness, the reformers tried to convince the public that institutionalization was as suitable a fate for the feeble-minded as it was for lunatics and idiots. This is why Helen MacMurchy could write about the "need of caring for those who are mentally defective and the serious danger they are to the public and themselves while they are at large."[18] And the direct link between lunacy and feeble-mindedness was drawn on May 22, 1903 when the *Globe* noted that Premier George W. Ross and Provincial Secretary J.R. Stratton had received a deputation from the NCW asking that "the Government take steps to care for feeble-minded women and girls who, if left to themselves were the prey of the evil disposed. Mrs. Willoughby Cummins explained that the careful observation of members of the National Council had revealed very many painful cases of the evils of allowing feeble-minded women to be at complete liberty. The children of all such women were of a lower scale of intelligence than their parents and this helped to explain the serious increase in lunacy. Mrs. Boulbee said that the number of feeble-minded mothers and illegitimate children was rapidly increasing." Social reformers were also relentless in their pursuit of statistics linking feeble-mindedness with recognized crimes such as prostitution. In these cases too, the object was to establish a relationship between feeble-mindedness and danger to the community, and to demonstrate that as long as feeble-minded women were not segregated by sex in custodial institutions, then crimes connected with feeble-mindedness would continue to spread.

At the same time as the social reformers cast the feeble-minded in a dark light in order to argue the case for social control, they also put forward a different, much more sympathetic case. The feeble-minded were said to be permanent children, they were people with the bodies of adults but the minds of children. Put this way, the plight of the feeble-minded was intended to invoke pity. Their needs were those of young children, they needed attention, patience, love, and above all, permanent supervision.

It was because so many people accepted this view of the feeble-minded that objections were constantly raised to their presence in jails, houses of refuge, lunatic asylums and the other welfare or punitive institutions in the province. Moreover, because the social reformers also viewed the world as rampant with male predators hunting for innocent feeble-minded women, the helplessness of the women was brought into strong relief. One of the main objectives of the movement, therefore, was to get the government to establish special institutions for the custodial care of feeble-minded women. From 1899 on, in association with other pressure groups, the National Council of Women petitioned provincial legis-

latures, spoke to the public and sent deputation after deputation to the Premier or to the Provincial Secretary trying to get some commitment from the government to provide custodial care for feeble-minded women.

With her contacts in government, with various pressure groups and with foreign, particularly British organizations concerned with the feeble-minded, Helen MacMurchy played a key role in publicizing the issue. Not only did she visit England and meet there with authorities such as Mary Dendy of the Lancashire and Cheshire Society for the Permanent Care of the Feeble-minded, but she visited Dr. Ashby, a close friend of and advisor to Mary Dendy. In June 1909, MacMurchy was instrumental in getting Mary Dendy to visit Toronto and lecture before the Women's Canadian Club, "on which occasion a large and interested audience listened closely to her account of work for the feeble-minded in England."[19] Later in her visit, MacMurchy arranged for Miss Dendy to visit some of the Toronto public schools. Together, albeit as Dendy admitted in "a somewhat hurried enquiry," they examined about 1,800 children. Dendy concluded that about one percent of these were mentally defective, except among the Jewish children for: "The Jews have very few mental defectives." On June 18th Dendy addressed the Board of Education at their regular meeting, giving what was a "joint" report on the problem. The result was that the Chairman of the Board, James Simpson, moved that teachers be asked to report to their Principals on the number of children who were in their opinion mentally defective.[20]

By 1909, it seemed that the efforts of MacMurchy and the various interested pressure groups would be successful, for after Provincial Secretary Hanna met with 150 delegates from the National Council of Women the *Globe* announced that "the Government will probably bring a comprehensive scheme for the care of feeble-minded women before the legislature during the next session."[21] And on March 11, 1911, the *Mail* reported: "As a result of investigations which have been carried out on behalf of the Provincial Secretary's Department by Dr. Helen MacMurchy, a Government Bill was introduced by the Minister of Education yesterday for the establishment of special classes for mentally defective children and the medical care of those who attend the classes."[22]

The Provincial Association for the Care of the Feeble-Minded

Nineteen hundred and eleven was a watershed year for the movement for it marked the inception of a single-issue pressure group solely concerned with the issue of the feeble-minded. On March 22, 1911, the largest deputation ever concerned with government legislation for the feeble-minded appeared at the provincial legislature in Toronto. The delegation was headed by Mayor G.R. Geary of Toronto, and included some of the leading members of Toronto's social and political élite as well as representatives from the Associated Charities, the Infant's Home, the National

Council of Women, the Salvation Army, the Household Economic Association, Travel Clubs, the Culture Clubs and others.[23] One year later, on March 18, 1912, both Mayor Geary and Controller J.O. McCarthy moved in Toronto City Council that a conference on the problem of the feeble-minded and mentally defective children be held at City Hall. Two days later a meeting was held and once again was attended by representatives of the major pressure groups of the time as well as by members of Toronto's social and political élite. In addition to Dr. MacMurchy, the mayor and a number of members of Toronto City Council, also present were Dr. F.J. Conboy of the Board of Education, later to become Director of Provincial Dental Services and Mayor of Toronto from 1941 to 1944, Captain Fraser of the Salvation Army, Commissioner J.E. Starr of the Juvenile Court, and Dr. J.T. Gilmour, Warden of Central Prison.

The following month a Committee appointed from the members of the Conference presented a brief report admitting that it was difficult to establish the exact number of feeble-minded people in Toronto, but estimating that there were at least 625 under fourteen years of age, and 500 over fourteen "who would come under the classification of feeble-minded or mentally defective."[24] There then followed a brief summary of legislation dealing with the feeble-minded in Great Britain, New Zealand, Massachusetts, Rhode Island and elsewhere. The thrust of this part of the report was to show that in other countries and in various parts of the U.S. the feeble-minded had already been brought within the scope of legislation, that they could be brought before a court (according to the report, in Massachusetts and Rhode Island, "any person who thinks such a feeble-minded person requires care and protection for his own welfare or for the welfare of the public" could bring a feeble-minded person before a District Court) and, depending upon the jurisdiction, could be placed in various kinds of institutions under permanent care. The report then went on to recommend that the City of Toronto establish a register of feeble-minded persons, that the Board of Education increase the number of special classes for mentally defective children (at the time there were two such classes in operation), that the City Health Department provide medical examination for "delinquents apparently mentally defective," and that the government establish a "training school of the residential colony type for the study, oversight and education of feeble-minded persons throughout the Province in need of custodial care." The committee also recommended that the various Boards of Aldermen of the cities and towns in Ontario ask the government to pass legislation, among other things, repealing legislation requiring the boards of management of charitable and industrial institutions "to place out feeble-minded persons" three years after committal; to allow "the easy transfer of feeble-minded persons from industrial schools and other institutions to the proposed Provincial Training School;" and to allow these institutions to "retain control" over "inmates not only until the age of twenty-one years, but also for such further period as may be necessary in order to provide

for their own and the community's safety."[25]

The policies recommended by the committee were coherent and consistent. Their intent was to identify those people who might be feeble-minded, examine them, and then if necessary to permanently institutionalize them. The cities and towns would provide the apparatus for identification and examination, but the province was expected to provide a custodial institution. In addition, regulations were to be changed to facilitate the placement of feeble-minded persons in a custodial institution once they were found in the existing welfare institutions of the province.

Shortly after this report E.R. Johnstone, a native Canadian and principal of the Training School for the Feeble-Minded at Vineland, New Jersey, was invited to Toronto by the committee. It is not clear exactly who recommended Johnstone, but most likely it would have been Dr. MacMurchy. Johnstone spoke at Convocation Hall of the University of Toronto to a large and distinguished audience which included W.J. Hanna, the Provincial Secretary, Dr. N.A. Powell, president of the Academy of Medicine, G.T. Somers, president of the Board of Trade and J.P. Downey, superintendent of Orillia. In his speech Johnstone recommended pretty much the same kind of legislation as had been put forward by the committee: medical inspection of children in the public schools; identification and placement of feeble-minded children in special classes; the provision by the province of custodial institutions for those who could not benefit by training.

At the conclusion of the meeting Dr. Powell moved and Mr. Somers seconded a resolution asking that the various cities and towns in Ontario send delegates to Toronto along with the Toronto Committee for the Care of the Feeble-Minded "for the purpose of forming a Permanent Provincial Association."[26] W.J. Hanna commented that the matter should be taken up by the municipalities and the public schools and that the government would "then be pleased to see what they could do."

Finally, on November 8, 1912, 100 delegates from twenty Ontario municipalities attended a day-long conference on the problem of the feeble-minded. In her report for that year Dr. MacMurchy gives a list of some of the luminaries who attended the conference. Among them were Mayor H.C. Hocken and Controller J.O. McCarthy of Toronto, Mayor F.J. Hoag of Kingston, the president of the National Council of Women, Mrs. F.H. Torrington, Mrs. A.M. Huestis, another Toronto woman activist prominent in the Canadian Public Health Association, the National Council for the Prevention of Venereal Disease and president of the Toronto Branch of the Hygiene Club, and assorted politicians, educators and clergymen.[27] Dr. MacMurchy personally greeted the delegates as they arrived and gave the opening address. During the course of the meeting a number of resolutions were passed. One called on the province to provide custodial institutions for the care of the feeble-minded, with the municipalities paying for the upkeep of their residents up to the age of twenty-one, after which the province would make them

wards of the Crown. Another asked that the Marriage Act be amended to prevent the marriage of mental defectives and yet another asked that a permanent executive be chosen from the conference, and that it "be instructed to press on the Government the desirability of introducing such legislation."[28] As a result the Provincial Association for the Care of the Feeble-Minded was formed with a province-wide executive of twenty-two members. The president was Controller J.O. McCarthy of Toronto, the first vice-president was Mrs. Torrington, President of the NCW, while the rest of the executive committee consisted of an assortment of politicians, educators and medical doctors including, of course, Helen McMurchy.

For the next seven years the Provincial Association for the Care of the Feeble-Minded (PACFM) worked in conjunction with other social reform organizations in leading the fight to get the government to implement the various resolutions that had been passed concerning the feeble-minded over the previous decade. But the government was cautious. At the November 8 meeting, W.J. Hanna was quoted as follows: "I have nothing to say beyond this, that the matter has been the subject of more or less discussion between a deputation from the city, headed by your chairman, Controller McCarthy and the government. The government has given this matter some consideration and should the municipalities decide to take action, either individually, or in groups, I think I can say that the municipalities will not be disappointed in the part the government will take."[29]

The Reformers Thwarted

Despite years of pressure from the PACFM and other groups, however, the movement never did get the province to help fund a separate custodial institution for the feeble-minded, for the province and municipalities could not reach agreement on sharing the funding. Over the years, legislation was passed making it easier to keep feeble-minded people in the various provincial institutions, forbidding the marriage of mental defectives, and expanding the auxiliary class system, but except for building two 150-bed cottages for men and women at Orillia after 1913, no separate institution for the feeble-minded was ever constructed.

In 1912, a new "Act Respecting Houses of Refuge" was passed making it compulsory for counties to establish houses of refuge if they had not already done so. Most important, whereas the previous statute had included "idiots" as eligible for commitment, the new statute provided for the commitment of "feeble-minded persons not fit subjects for commitment to Hospitals for the Insane or to Hospitals for Idiots but for whom special custodial care is necessary now." Obviously, this Act was intended as a form of preventive custody for feeble-minded women for a new section also provided that: "Where the physician having the care of the health of the inmates of a House of Refuge certifies that a female inmate between sixteen and forty-five years of age, on account of natural imbecility is so feeble-minded as to render it probable that she would be

unable to care for herself if discharged from such houses of refuge, she shall not be discharged until such physician with the approval of one of the Inspectors of Prisons and Public Charities orders her discharge."[30] Another statute that bears the clear imprint of the social reformers is the "Act Respecting Houses of Refuge for Females" of 1913. This was a revision of an act dating back to 1893, but the revised version repeats the exact words of the 1912 statute restricting the woman's right to discharge.[31] And in 1919 "The Females Refuge Act of 1919" provided that the inspector and two physicians might transfer a woman from the refuge to "the Hospital for the Feeble-Minded."[32] But there is little evidence about the exact number of feeble-minded women in the various refuges, and about the exact numbers of those who might have been transferred to Orillia after 1919.

A return to the legislature on February 4, 1889 shows that in 1887, out of 685 inmates of the existing nine houses of industry supported either partially or wholly out of municipal funds, 94 or 13 percent were either "idiots" or "imbeciles"; while in 1888 out of 808 inmates, 132 or 16 percent fell into these categories. After that date, however, there is nothing but partial data. Helen MacMurchy insisted that around two-thirds of the inmates of houses of refuge were feeble-minded, and in 1915 she claimed that there were 1,700 feeble-minded inmates in "refuges, gaols, orphanages, industrial schools and other institutions."[33] But even taking account of the superintendent's tendency to exaggerate the numbers of feeble-minded (because the term was so vague, it could be applied to almost anyone), MacMurchy's predeliction for presenting statistics without giving sources makes this estimate completely unreliable. Moreover, because of the failure to clearly distinguish the feeble-minded from social failures, even if the numbers given by MacMurchy were an accurate reflection of data from the various sources, they still would not tell us very much about how many people were actually feeble-minded, rather than suffering from some other problem or disability. Nor is there any evidence on how many people were sent from the houses of refuge and houses of industry to Orillia. It is clear, however, that the fobbing-off process was at work, for J.P. Downey, the superintendent of Orillia in 1919 noted on more than one occasion that the other provincial institutions were sending Orillia "the flotsam and jetsam of the human sea...the incorrigibles."[34] Apparently what happened is that the houses of refuge and other institutions kept their able-bodied workers and tried to send troublemakers or the poorer workers to Orillia in the guise of idiots or feeble-minded. Thus, Downey reported that during the First World War: "Anyone who could do work at home or in any House of Refuge or Correction was retained there and to us came only those who were an absolute burden."[35]

Moreover, to the extent that the refuges retained able-bodied men and women, regardless of whether or not they were feeble-minded, then to that extent the social reformers were thwarted, since the main objective

of these statutes was to ensure that the feeble-minded were placed in permanent custodial care in institutions such as Orillia. Another problem was that some physicians who visited the houses of refuge were reluctant to use the term feeble-minded because of its vagueness. Moreover, as Mrs. Adam Shortt, an Ottawa doctor complained: "Unfortunately...there is no special organization in the Province whose business and responsibility it is to go hither and thither snatching these grown-up children out of harm's way and placing them under custodial care. If there were some such organization...then the amended House of Refuge Act, of which so much was expected, might become operative to some appreciable extent."[36]

Expansion of a system of special education for feeble-minded children was one area where the reformers' efforts were moderately successful. Obviously, given their understanding of the nature of feeble-mindedness, great stress was put on the early identification and treatment of feeble-mindedness. Here too, Helen MacMurchy was particularly active for not only was she prominent in the movement to establish special classes for backward learners in the school system, but she was one of the early, and ardent proponents of educating mothers in how to better feed and take care of their children. But as was generally true of the movement, the humanitarian attitude toward feeble-minded children had darker overtones. MacMurchy's enthusiasm for the establishment of special classes for backward children was prompted as much by sympathy for these children as by a desire to use the school system to identify those feeble-minded children who "cannot be regarded as fit for anything but permanent custodial care in Homes with industrial colonies attached."[37] Here again we encounter a mixture of sympathy and pity on the one hand, and callousness and a desire for punishment on the other. Yet, given the logic of the movement, these were not necessarily contradictory. MacMurchy and the other social reformers believed that only a certain percentage of feeble-minded children could be trained in elementary skills, or in the case of girls, to be sexually responsible. Those who could not be so trained would have to be permanently institutionalized. The task of the special classes would be to differentiate between the two groups. As had been the case in England and elsewhere, by defining feeble-mindedness almost exclusively in terms of performance at school or success in society, the social reformers clearly implied that those who failed were feeble-minded, while those who succeeded were not. But the penalties of educational or social failure could be very great indeed — especially for single women.

Moreover, there was some confusion about the labels to be applied to those who were backward for reasons other than feeble-mindedness and to those who were feeble-minded. Dr. MacMurchy herself was not particularly clear on the distinction. In her 1908 report she emphasized the importance of differentiating between children who were "only backward" and those who were mentally defective. The backward child might

be temporarily disadvantaged by poor nutrition, poor home care or by physical problems such as poor hearing or eyesight, all of which could be corrected by remedial measures. But, "no skill, no knowledge, no training — nothing — will ever change a mentally defective child into a normal child."[38] What then was the difference between the feeble-minded and the mentally defective child? Because of the obscurity surrounding these terms, when he was asked to draft the first Act Respecting Special Classes in 1911, Allan M. Dymond of the Law Department of the Legislative Assembly wrote to the Minister of Education: "I have avoided the use of the word 'defective' as there appears from the material I have read to be a great deal of difference of opinion as to just what it means."[39] Thus the 1911 Act simply refers to children who are "backward or abnormally slow in learning" or "who from physical or mental causes require special training in education."[40] And in her 1914 report MacMurchy argued that the purpose of the special classes was diagnostic, that is, to determine whether a backward pupil was merely backward or feeble-minded. If the latter, then, according to MacMurchy the child should be transferred into a "permanent and happy home for their permanent childhood, for they will always be children."[41]

While the province was making concessions regarding provisions for transferring inmates from the houses of refuge to Orillia, and the extension of the auxiliary class system, no agreement could be reached on a new institution for the feeble-minded. On April 20, 1915, Provincial Secretary W.J. Hanna attempted to resolve the dispute by suggesting the appointment of an advisory committee to the government, with representatives appointed by the government, the Mayor and Board of Control of Toronto, the various public charities of the city and the Department of Education. The committee that was finally appointed consisted of a number of members of the Provincial Association for the Care of the Feeble-Minded, including Helen MacMurchy who was chosen jointly by Hanna to represent the Office of the Provincial Secretary and by R.A. Pyne who chose her as Inspector of Auxiliary Classes to represent the Department of Education.

Inevitably, on October 6, 1915, the advisory committee strongly supported the same policies that had been advocated for years by the social reform associations: establishing classes for backward children in public schools, establishing a register of "all Mental Defectives in Toronto," opening a "Psycho-educational Clinic for medical investigation, diagnosis and advice," which would be similar to the Social Service Clinic already in operation in the Toronto General Hospital under the supervision of Dr. C.K. Clarke; and building a custodial farm-type institution to which would be transferred 213 "mentally defective children" who were already in children's homes, orphanages, and industrial schools near Toronto. The committee also suggested a cost-sharing arrangement, with the province and Toronto providing maintenance grants, and a by-law to be submitted to the ratepayers authorizing the City of Toronto to

spend $200,000 for the cost of building the farm colony.[42]

There can be no question that the main obstacle to the government's acceding to the requests for funds was Hanna's reluctance to make an open-ended commitment that would cost the province, according to his calculations, $1,000,000. Since this would mean raising the tax rate Hanna wanted some sign of support from the municipalities that they would not object to such a rise, and that they would contribute to the establishment and maintenance of such institutions. There was one other difficulty: at a meeting with the Advisory Committee Hanna "remarked that the more closely this problem was studied the larger the number of mental defectives was found to be, including for the whole Province over 7,000 persons...."[43] Here Hanna touched on a sensitive point.

For pressure groups to be credible they must provide accurate and consistent information to policy-makers. Yet over the years the chief spokesman of the movement, Dr. MacMurchy, was unable to give precise figures either on the total numbers of feeble-minded in the province, or of the percentage of feeble-minded people in various categories. In her sixth report as inspector of the feeble-minded released in 1912 she stated that there were between 2-4,000 "idiots, imbeciles and feeble-minded in Ontario."[44] In her seventh report she quoted superintendent J.P. Downey of Orillia who said there were 6,000 feeble-minded people in Ontario, although it is not clear whether Downey was using the term "feeble-minded" as an inclusive category or to refer to the higher grades of mentally retarded people. In her ninth report as inspector, published in 1915, MacMurchy stated that in Ontario, the percentage of mentally defective people was around .2 to .3 percent (less than the English finding of .46 percent), and on this basis she suggested there were 5-7,500 feeble-minded people. In her tenth report she stated that the number of feeble-minded were equal to the number of insane, so that her estimate was 7,700 feeble-minded people in Ontario. MacMurchy's figures on the numbers of feeble-minded within categories were even more speculative, based as they were on occasional evidence gathered from those authorities in charge of jails, prisons, houses of refuge and industry and other provincial institutions. In 1911, for example, MacMurchy quoted one superintendent of a house of refuge who claimed 75 percent of the inmates were feeble-minded. But MacMurchy estimated the number of feeble-minded in the houses of refuge at 20 percent.[45] When Mary Dendy, founder of the Sandlebridge Schools for the Feeble-Minded in England, visited Ontario she examined a number of Toronto school children and estimated that 1 percent were feeble-minded. But MacMurchy thought a better estimate was .3 percent.[46]

Dr. C.M. Hincks, who worked under Dr. Clarke at the Psychiatric Clinic of the Toronto General Hospital, admitted the difficulties in 1916 at a symposium on the feeble-minded when he said that for a long time estimates of the numbers of feeble-minded had been made by taking the percentages from other areas, and then applying them to Toronto. "Fig-

ures gathered in this way were not convincing and so when we went to the Parliament Buildings and the Board of Control the apple cart was often spilled when direct questions were asked. We simply had to guess, and if I might use the vernacular of the street we not only guessed, but we gassed, and our efforts invariably ended in the latter."[47] But exactly why MacMurchy always argued for a lower percentage of feeble-minded people in Ontario than elsewhere is difficult to say. Perhaps one reason is that from her position at the top ranks of the Ontario bureaucracy, it would have been imprudent to accept the higher percentages since this would have given more ammunition to those who were arguing that Ontario's provision for mentally retarded people was inadequate. At the same time, however, MacMurchy consistently gave very high estimates of the percentage of feeble-minded people in various social problem categories such as illegitimate mothers, prostitutes, and the inmates of the prison or refuge system. In this way she dramatized her view that the key to a myriad of social problems lay in institutionalizing the feeble-minded, without criticizing existing government policy. This explanation gains credence from the fact that in January 1916, MacMurchy was criticized by some speakers at a meeting of the Academy of Medicine in Toronto for overestimating public accommodation available for the feeble-minded in Ontario as compared with New York, New Jersey and Massachusetts.[48]

Finally, frustrated at the government's inaction, C.K. Clarke, a leading Canadian psychiatrist, superintendent of the Toronto General Hospital and recently elected President of the Toronto Branch of the PACFM, entered into contact with N.W. Rowell who was then leader of the Liberal Opposition. At that time the Opposition was using MacMurchy's tenth report where she was critical of the government ("Are we doing our best for the feeble-minded?" she asked, "No. Certainly not.") to move an amendment condemning government policy.[49] The motion was defeated but Clarke wrote to Rowell:

> The whole thing is most amusing and shows the curse of political control in public institutions. It seems to me that you have remarkable texts from which to preach your sermon, as no better illustration of the absurdity of our present system could be furnished than that of Mr. Downey and his institution for the feeble-minded at Orillia. No one objects particularly to Mr. Downey, but his reign at Orillia has been little better than a joke. He is ignorant of his subject, is utterly opposed to all scientific advancement, and his institution does not offer one thing better than simple custodial care of a number of idiots and imbeciles. He does not even attempt to reach the class in which we are particularly interested; that is, the class which is such a menace to the community — namely, the high-grade imbecile. With Mr. Downey's and Miss MacMurchy's reports I think we have a splendid opportunity to enlighten the public.... A

> feeling of irritation is arising in the community, and this feeling must make itself felt by the Government sooner or later.[50]

In a memo of December 14, 1916, Clarke explained that it was pointless to compare Ontario with some of the "progressive States in America as they are doing educational work which we do not attempt," and he noted that according to Superintendent J.P. Downey there were only 154 high grade defectives at Orillia. From this Clarke argued that Orillia was not accomplishing the task of educating or training the feeble-minded who "are at present a menace to the community and who may be made of use to themselves and to the world by being given a chance to partly earn their own living and to be protected from themselves."[51]

In the early part of 1916 W.D. McPherson replaced W.J. Hanna as Provincial Secretary. Some time before his appointment, however, he had been in contact with S.D. Gwynne, a prominent Conservative lawyer and a member of the PACFM. At that time McPherson had suggested the appointment of a commission to "investigate the subject of the public provision for the care, custody and treatment and training of the mentally deficient including epileptics."[52] But upon McPherson's appointment the PACFM immediately launched a renewed campaign to get the provincial government to finally commit itself to a custodial institution. By early 1917 it appeared that success was close at hand, for at a meeting between Premier Hearst and the Toronto branch of the Provincial Association for the Care of the Feeble-Minded it was decided that the City of Toronto would incur the capital expenditure for an institution for 500 feeble-minded children, with the Board of Education and the Separate School Boards contributing $100 per person per year for maintenance and the province $50. But the day after the meeting Premier Hearst still harboured doubts. In a memorandum to McPherson, he wrote: "The troublesome part, however, is this, that they only propose to care for high-grade feeble-minded and for these only until they reach twenty-one years of age. Dr. Clarke says there are over 2,000 feeble-minded children in the Public Schools. The proposition of the deputation would only care for one-quarter of these, who according to the deputation need care in the schools, not speaking of the large number outside of the schools, so that the proposition of the Committee is simply nibbling at the question after all."[53] Moreover, Hearst asked what was to be done with the feeble-minded after the age of twenty-one since it was generally admitted that they were then an even greater menace to the community. And he expressed some reluctance to see them turned over to the province at age twenty-one:

> Another objection is that the proposed Toronto Institutions will only take the high-grade defectives and leave the idiots uncared for. That would mean that the Provincial Institutions would be filled with patients largely of an idiotic class. An Institution of this kind would, I understand, be a difficult if not a hopeless proposition. At Orillia,

> for instance, at the present time the high-class patients can be employed on useful work around the farm, producing the vegetables and other things required in an institution, and generally looking after the work. Not only this but they help to amuse, brighten up and care for the lower-grade defectives. I have seen entertainments put on by the higher-grade defectives at Orillia that would be a credit to children possessing all their faculties.[54]

Obviously Hearst was not the least bit concerned with the morality or legality of the case for institutionalizing the feeble-minded, but rather with the government's overriding preoccupation: to keep asylum expenses as low as possible. Certainly, in the case of Orillia there was no question of educating or training the inmates, indeed this had hardly ever been the objective. But it is equally clear that asylum policy had little to do with the originally stated intentions, for the goal of efficiency had become paramount. Since, as Hearst realized, the efficiency of the asylums now depended to a large extent on the work of the inmates themselves, decisions about asylum policy were taken so as to make the best possible use of inmate labour. This point was put explicitly by J.P. Downey in his annual report for 1913. There he observed that:

> the maintenance of this and kindred institutions is kept well within the financial resources of the Province by the labour of the patients. Were we to stop the work of our men in the fields, and barns and shops; of our girls in the sewing room, laundry and wards, and engage outside help for these various services, the annual expenditure would be enormously increased. If then, the Province and the municipalities have to care for the feeble-minded, the greatest service to that unfortunate class with the lightest burden on the people would, in my opinion, be rendered not by building and maintaining a separate training school for high grades but by developing the system under which the improvable cases can be trained according to their capacity....[55]

Most likely then, Hearst's views reflected those of Downey. Policy was shaped by the desperate need for labour in the institution, any threat to the supply of that labour was a threat to the institution itself, or would have forced the province to increase funding. The ostensible goals of policy were clearly being influenced by factors which bore little relation to those goals.

In the event, Hearst sent a list of questions about the proposal to McPherson who passed them on to MacMurchy. MacMurchy duly prepared a list of answers, submitted them to McPherson who, in line with the well-worn practice of not giving others credit for work unless you have to, submitted them under his own signature to Premier Hearst. The answers can hardly be said to have met Hearst's objections, although

there is no record of his actual response. As to the question of what would happen to "inmates" as MacMurchy referred to them after the age of twenty-one, the "great majority would have to be cared for permanently in suitable institutions." And as for what would happen to Orillia if it were drained of the higher ability patients who would be sent to the custodial institution, MacMurchy gave a rather confused response concerning private institutions which cared exclusively for the "higher grade" cases.[56]

Hearst seems to have agreed only that the province would provide $50.00 per year per pupil, if the City of Toronto and the Board of Education would pick up all other capital and maintenance costs. This was not in any way an endorsement of the proposal since Hearst had stipulated that prior to receiving these funds the city first had to find the land, get the money for the capital expenditure and then agree to contribute $100 per pupil. Moreover, at a meeting held May 31, 1917 at which McPherson, Controller O'Neill, the Property Commissioner, the City Solicitor and Thomas Bradshaw, the City Treasurer were present it became apparent that the city officials doubted the wisdom of the scheme. Throughout the meeting Bradshaw raised questions of a humanitarian kind, something almost unheard of in discussions concerning feeble-minded people. At one point, for example, he observed: "I understand the pupils are to be sent out permanently and be kept at the Institution day and night, practically a boarding school. I wonder how the parents of the children will take to that?" McPherson replied: "That is the only way you can deal with them." Later in discussing whether the authorities could compel students already attending public schools to transfer to the proposed training schools, Bradshaw again asked: "But could you compel them to attend? These pupils are backward and defective but these pupils are not harmful and it might be a question whether we could compel them." And later again Bradshaw said: "You can, however, imagine pupils that are defective but are not harmful in any way."[57]

By this time, however, the province seems to have decided to go along with the proposal to establish two industrial farm colonies, one for boys and one for girls, as long as the city would pay the capital expenditures and the Toronto Board of Education would give $100 per person per year for maintenance. Thus, in the 1917 session of the Legislature, the City of Toronto was granted permission to erect an institution for the care of feeble-minded children and to issue debentures for not more than $150,000 without having to submit a by-law to the ratepayers. But the city continued to temporize, reluctant to commit itself to capital expenditures estimated at around $150,000 and to the $100 per person per year maintenance contribution. At the same time, assuming that the city was about to begin construction of the institution, the PACFM sent a letter to Premier Hearst on May 1, 1917 asking that a Royal Commission be appointed to investigate the problem. In the letter, Dr. Clarke and Captain Gordon Bates, Secretary of the Toronto Branch of the PACFM said that the question of what to do with the "whole class of feeble-

minded" and of "compulsory care for feeble-minded children" still had to be clarified.[58] Since Provincial Secretary McPherson had already suggested the idea of a Royal Commission some years before, on November 11, 1917, Premier Hearst appointed Justice Frank Egerton Hodgins as a one-man Royal Commission on the Care and Control of the Mentally Defective and Feeble-Minded in Ontario. The Hodgins Report appeared in 1919.

The Creation of a Social Problem

The appointment of a Royal Commission to investigate the problem of the feeble-minded demonstrates how important the problem had become in the eyes of the government as well as its uncertainty about how best to proceed in dealing with it. One of the difficulties lay in the ambiguity of the term itself. Since 1840 the term feeble-minded had been used in North America in two different senses: as a synonym for all mentally retarded people, that is, in the same way as the term mental defective, or, to refer to the higher levels of mental retardation, to those mentally retarded people who bordered on normal intelligence. This latter use of the term was prevalent in Great Britain and had been given a statutory definition in the 1913 Mental Deficiency Act. In Ontario the term was used in both senses but more frequently in the same way as in Great Britain. Moreover, feeble-mindedness had been closely linked with social failure and with specific social problems. The Ontario policy-makers and social reformers had been deeply influenced by the work of Francis Galton, Karl Pearson and the eugenics movement in Great Britain and the U.S. and by the findings of Richard Dugdale and H.H. Goddard in the U.S. Evidence seemed to indicate a clear link between feeble-mindedness and the major social problems of the time. Since the feeble-minded were generally distinguished from other mentally retarded people by the lack of physical stigmata and their ability to deceive even physicians as to their real nature, only the most highly trained experts could decide whether an individual had run into trouble because of a natural deficiency of intelligence or responsibility, or because of an intelligently motivated act of free will.

The latitude this gave to authorities involved in the labelling process in deciding who was and who was not feeble-minded, was enormously wide. Some of those described as feeble-minded were obviously nothing of the kind. For example, in one of the widely cited texts of the time, *Mental Defectives: Their History, Treatment and Training,* Martin W. Barr of the Pennsylvania School for Feeble-Minded Children gave brief case summaries of "high-grade imbeciles." Among them was:

> Case A. — A.S. Boy; aged sixteen years with the intelligence of a normal child of twelve. Powers of attention and imitation fair. Excellent memory. Does not care for study, but is fond of reading boys' books. Has a clear high tenor voice and is interested in athle-

> tics. Clever with his hands — a ready type-setter; a good cornetist and fond of active employment. Obedient and affectionate, is a remarkably clean-minded, wholesome boy, with an attractive personality.... Case B. — M.S. Female; aged 20 when photograph was taken. Brown hair and eyes. Sight slightly defective. Distinct enunciation and excellent vocabulary; can read and write, is very deft with her hands — excellent in sloyd work, embroidery, a good seamstress and housemaid....[59]

And Barr quotes Isaac N. Kerlin who was Superintendent at the Pennsylvania Training School as defining the "high or best grade" of imbecile as possessing "all the attributes of intelligence in a limited degree; they are taught to read and write in some instances fluently, to calculate minor questions of arithmetic, and approach the lower range of common intelligence in their relations to life as found among the ignorant; in their most advanced grade they are lacking only in those powers of discrimination, judgment and will power, the attributes of a sound man; if they exercise them at all it is in mimicry of associates and superiors rather than from their personal possession."[60]

At the highest level of feeble-mindedness there also existed another category barely distinguishable from normalcy: moral imbecility. According to Barr: "In the highest grade [moral imbecile] there is a refinement of evil; the mental powers are subordinated wholly to a perverted moral sense, exhibit often a craftiness and skill truly satanic while the not infrequent association of great physical beauty and bodily vigor together with the total absence of physical stigmata, renders the recognitions of this type except by experts impossible; they would literally deceive, often, the very elect."[61] These views were widely shared. In a special issue of the *Public Health Journal* of 1914, Dr. George S. Strathy of Toronto wrote: "The 'feeble-minded' question is a cause of the more important modern social evils. The problem of dealing with the idiot and the imbecile is comparatively easy because they are recognized at a glance and treated accordingly by even the most unobservant among the general public. More difficult is the case of the high-grade defective or moron, seldom recognized by the ordinary observer, and receiving scant sympathy...for the extraordinary acts he commits without fear of consequence. The appearance of the idiot or imbecile is his safeguard. The prepossessing face and manner of the moron is often greatly to his disadvantage."[62]

When it came down to non-experts, however, the identification of the feeble-minded seems to have been a rather personal judgment. In evidence given before the British Royal Commission on the Care and Control of the Feeble-Minded, Philip H. Bagenal, a General Inspector with the London Board of Guardians, observed: "From my observation of vagrants, and I see a certain number of vagrants every week of my life, there does seem to be a stamp on a certain proportion of them — there

is a sort of vacancy about them, a want of motive power and energy, a want of will power which I think are of the character of feeble-mindedness."[63]

Until the adoption of the intelligence test, something which did not occur until 1916 in Ontario, it is most likely that similar kinds of assessments were made wherever mental deficiency was suspected as the cause of social problems.[64] The Ontario social reformers unquestioningly accepted the conceptual and statistical links between feeble-mindedness and social failure. For example, Dr. Strathy noted that: "An experienced and levelheaded social worker recently expressed the opinion to the writer that the great majority of the chronically poor in Toronto are defectives."[65]

The extent to which feeble-mindedness was thought to lay behind the major social problems of the time is remarkable. According to E.R. Johnstone of the Training School for the Feeble-Minded, Vineland, N.J., writing in the same special issue: "That much of the increase of poverty, crime, epilepsy and even insanity is due to feeble-mindedness is undoubted. Every careful student of the facts already known realizes that our social burden will be greatly lightened if the feeble-minded are properly segregated."[66] According to Lucy M. Brooking, Superintendent of the Alexandra Industrial School, Toronto: "From 30 to 40 percent of our juvenile delinquents are of defective mentality *or they would not be delinquents* [her italics]."[67] Said C.K. Clarke in a paper read in 1916 before a meeting of the Academy of Medicine: "When you realize that at least 60 percent of the prostitutes are feeble-minded, you may easily figure out the possibilities. Remember too that those prostitutes are so commonly the distributors of syphilis which has become such an appalling menace in this community."[68] Although she never claimed that incest was particularly prevalent, Dr. MacMurchy frequently cited one or another case of incest among feeble-minded people in her reports.[69] And Dr. MacMurchy confirmed the prevailing belief that feeble-minded women had a higher birthrate than normal women by stating that the proportions were 7:4.[70]

Initially feeble-mindedness had been characterized primarily as a moral disease. Thus the mere presence of a feeble-minded person was a threat to the moral stability of normal people. In her 1909 report Dr. MacMurchy quotes Dr. Fraser, Superintendent of the School for the Blind in Halifax, Nova Scotia, as saying that the feeble-minded "furnishes a real menace alike to the physical and moral status of our people."[71] In 1916 Dr. H.L. Brittain who was the founder and director of the Toronto Bureau of Municipal Research said that the feeble-minded "are more helpless and more dangerous centres of mental and moral loss to normal children.... Mingling normal and subnormal children always results in a dead loss to both classes."[72] The moral threat posed by the feeble-minded also derived from the lack of sexual restraint that was thought to be one of their major characteristics. For Helen MacMurchy

this came from the notion that the feeble-minded were somehow lower on the scale of humanity than normal people. "It seems very probable that the mentally defective child represents a reversion to an ancestral type of humanity when on its way up to civilization.... A defect, and disproportion, similar to that found on the intellectual side, is to be found on the moral side. In the normal individual the higher faculties, at least as a rule, control the lower appetites and passions. There is some sort of balance, judgment, moderation and government. In the sub-normal individual, the lower animal faculties often rule, because the higher powers are scarcely present."[73]

The increased attention paid to the social problem of feeble-mindedness was linked to the major social and economic changes that had been taking place since the late nineteenth century, and which had been heightened by the coming of World War I. In Ontario, the population had risen from 2,182,947 in 1901 to 2,933,000 in 1921, an increase of 34 percent while the urban population of Ontario had leapt from 818,998 in 1891 to 1,706,632 in 1921, an increase of 108 percent in thirty years. Toronto had jumped from 96,196 in 1881, to 521,893, an increase of 442 percent in forty years. Similar or even more drastic population changes were taking place throughout North America and Europe. With rapid social change came an increase in social problems. From 1872 to 1896 the Liberal Government of Oliver Mowat invested heavily in public institutions and programs to cope with social problems. In 1880, at a speech to the National Conference of Charities and Corrections in Cleveland, J.W. Langmuir noted that the province maintained "four hospitals for the insane, one asylum for idiots, an institution for the education of the deaf and dumb, an institution for the education of the blind, a central or intermediate prison for male offenders, a reformatory for boys, a reformatory for women and an industrial refuge for girls." He also noted that of the charitable institutions "founded and erected by cities and towns by private individuals in a corporate capacity and which are only partially maintained by the Province, but whose affairs are under the inspectorial supervision of the Government" there were twelve general hospitals, fifteen houses of refuge, twenty-four asylums for orphans and neglected and abandoned children and four magdalen asylums."[74] At the turn of the the century the number of public institutions continued to grow apace. However, the tide of human misery and misfortunes continued to mount.

But social problems do not merely occur, they are created. Different societies have different conceptions of what a social problem is and how it is to be treated. Thus, there would have been no menace of the feeble-minded without the myriad of social reform groups and activists who formed the custodial movement after 1900. Without exception the social reformers were from the middle class, and a large proportion of them were women. Although women shared with their male counterparts contemporary opinions about the source and nature of feeble-mindedness, there was one characteristic peculiar to the feeble-minded which was sup-

posed to be of particular relevance to women: the feeble-minded were not thought to be fully responsible for their actions. They were childlike, or child-adults. As Helen MacMurchy put it in 1908: "They cannot fight the battles of life, or meet its temptations. They will always be children and therefore must be cared for and helped in a permanent parental home where they are trained, taught useful employments, their powers made the most of and their earning capacity utilized for their own support and happiness."[75]

The irresponsibility of the feeble-minded was a common theme of the period, and was one reason for the outcry against committing them to correctional institutions where they mixed with common criminals. Since they could not help themselves the feeble-minded were deserving of sympathy, pity, love and kindness. And since women were thought to possess these qualities in abundance, it was natural to assume that they had a particularly important role to play in arguing the case for a coherent policy of care for the feeble-minded. Thus middle-class women could fulfill both their "nature" as well as their social ideals by condescending to help those who suffered misfortune mainly because of biological bad luck.

Not only were the feeble-minded like children, there were, of course, feeble-minded children. Since at this time there was great interest in child welfare in Ontario, with social reformers fighting for factory legislation limiting the hours and conditions of child labour, and for a whole array of social legislation from mother's allowances to orphanages, the female social reformers were naturally interested in the plight of feeble-minded children. And here the policies they advocated were shaped by their own ideas on the nature of the social order.

It is quite clear that one of the primary concerns of women social reformers was to preserve the family against the threat posed by the rising urban and industrial order. Since feeble-mindedness was so closely linked with crime, illegitimacy and prostitution, and since these were clearly threats to the family, then the prevention of feeble-mindedness became a matter of the utmost concern to female social reformers. But contemporary theories held that there was a basic division amongst the feeble-minded, separating those who could be educated or trained to take their place in normal society, and those who could not. For the latter the only alternative was permanent custodial care. Given the importance of identifying the feeble-minded before they disappeared into the normal population where they would aways pose a menace to society, as well as the crucial decision to be made concerning the question of institutionalization, a good deal of stress was put on providing special educational facilities for the feeble-minded. Since education concerned children, and since children were the particular concern of women, the female social reformers were prominent in spearheading the drive for special education for the feeble-minded.

The Inception of Special Education

The establishment of special classes for mentally retarded children first occurred in Germany in 1863, Norway followed in 1874, England in 1892 and then Switzerland and Austria. The first classes in the United States were established in 1894 in Providence, Rhode Island where a public day school for "backward boys and girls was opened." In 1889 Boston, Chicago and Philadelphia established similar schools.[76] The objectives were to remove feeble-minded children from the regular school system where they were thought to constitute a disruptive influence on the regular pupils; to provide feeble-minded children with special education suitable to their needs and particularly one that would make them self-supporting; to protect them from harassment by children in regular classes; and to determine which among them was incapable of education and training and should be sent to custodial institutions.

During the latter part of the nineteenth century opinions differed over the proportion of children who could, in fact, benefit from the special schools and return to their families or the community. During that period the *Journal of Psycho-Asthenics* was filled with discussions of this question and estimates ranged from 80 percent to one that held that "only a very small proportion of even the higher grade cases become desirable members of the community."[77] In Ontario, the role to be played by the special classes in identifying children for custodial institutions was particularly prominent in Helen MacMurchy's writings, especially since she was extremely pessimistic about the numbers of pupils who would return from them to the community. In her first report on the feeble-minded she suggested that 60 to 90 percent of mentally defective children would "not be able to live in the world at large without becoming degenerate, unemployable, criminals and alas, the parents of children still more mentally defective, degraded and dangerous than themselves."[78] Since MacMurchy had been appointed as a school medical inspector by the Board of Education on February 10, 1910, to inquire into the extent of mental deficiency in the schools, she was in an excellent position to lead a campaign to establish special schools in the Toronto school system.[79] When she examined 117 children whose names had been submitted by teachers and principals from the public schools, she found that 52 were not just backward, but clearly mentally defective. As a result of her investigation the Toronto Board of Education opened two "Special Classes" on September 19, 1910. These were the first special education classes in Ontario.[80] Soon after, the province passed "An Act Respecting Special Classes," on March 21, 1911. It gave power to boards of education or school trustees to establish a register of backward children or slow learners and it provided for provincial grants for the establishment of special classes. According to MacMurchy: "The real function of the special school is that of a clearing-house."[81] By this MacMurchy meant that the function of the special classes (or special schools) was not to educate mentally retarded children, for in her opinion this was impossible, rather

their purpose was to determine why children were backward or slow at their studies, whether from physical, environmental or intellectual reasons. "If it is poor health, bad sight, defective hearing, stammering, syphilis, anemia, fatigue, sitting up too late at nights, eating slate pencils, smoking cigars, drinking beer, wage-earning before the time, tuberculosis, rheumatism, heart disease, adenoids, enlarged tonsils, repeated infections, or any other removable cause, let that cause be removed so that the child may not lose his life, health and education, nor the State lose its time, its money and its citizens."[82] But, she urged, if the cause were mental defect, then it would be a waste of money to keep these children in special classes since they were uneducable. "They should be cared for and educated in a permanent residential home and school of the colony or village type."[83] For MacMurchy, special classes were not an end in themselves, for their purpose was not primarily educational. Rather they were to be the first step in a policy of identifying those mentally retarded children who needed permanent, institutional care.

As a result of ambiguities in the 1911 Act, the Auxiliary Classes Act of 1914 was passed providing for the establishment of special classes for children who "not being persons whose mental capacity is incapable of development beyond that of a child of normal mentality at eight years of age, are from any physical or mental cause unable to take proper advantage of the ordinary or separate school courses." Apparently this act was meant to *exclude* mentally retarded children from the special classes, for in 1919 new regulations were enacted providing for "training classes" for children "who can be educated or trained and whose mental age is not less than the legal school age."[84]

This marks the beginning of the distinction between those mentally retarded children eligible for admittance into the public school system in special classes, and those retarded children who were even excluded from special classes. Although most places in North America ultimately chose an IQ of 50 as the dividing line between the two groups, Ontario's regulations continued to speak of "mental age" until the 1950's — although it came down to the same thing. In the event, only a small number of training classes were established after 1919. Two Toronto classes in existence since 1910 had been discontinued by 1913, one operating in Hamilton was still functioning in 1919 and two more had been opened in Ottawa. One reason for the lack of training classes was the reluctance of municipalities to appropriate the necessary funds. Another reason was that as Inspector of Auxiliary Education after 1914, MacMurchy was in conflict with the education bureaucracy because of her attempts to control auxiliary education. Moreover, there is some evidence from MacMurchy's reports that parents were reluctant to allow their children into these classes since they often became the butt of the other children in the school. Some parents were also reluctant to put their children in a situation where they might become candidates for permanent institutionalization at Orillia.

MacMurchy's term as Inspector of Auxiliary Education and as Inspector of the Feeble-Minded came to an end in 1920 when she became head of the Division of Child Welfare in the newly-created Federal Ministry of Labour. The almost simultaneous departure of MacMurchy and the appearance of the Hodgins report marked a turning point in the fortunes of the custodial movement in Ontario.

The Report of The Royal Commission on the Care and Control of the Mentally Defective and the Feeble-Minded

Justice Frank Egerton Hodgins' 1919 report was the first attempt by the province to systematically inquire into all aspects of mental retardation policy. During the course of his research Hodgins visited institutions in Hamilton, Ottawa, New York, Washington and Boston, "perused an immense number of pamphlets, papers and addresses written or delivered by authorities in Great Britain and the United States, and the report of the Royal Commission in Great Britain," and listened to the testimony of experts from America and Canada.[85]

The report is particularly interesting because it is a mixture of the conventional wisdom regarding mental retardation and of revisionist theories which were then gaining ground. Particularly confusing are Hodgins' frequent references to the opinions of Walter E. Fernald, superintendent of the Massachusetts School for the Feeble-Minded at Waltham, Massachusetts and one of the leading authorities on mental retardation.

Fernald's ideas on the subject had begun to change quite drastically after 1900, to the point where he challenged some of the major tenets of the custodial argument. At one point, for example, Hodgins quotes at length from a May 1918 article by Fernald. There, Fernald noted that while in theory institutionalization of the feeble-minded was intended to prevent the "perpetuation of the feeble-minded stock," in fact people were actually sent to institutions "because they have become troublesome members of the community, or because their care entails much difficulty, under home conditions, with eugenic considerations quite secondary. In other words, the anti-social and lawless behaviour of the untrained feeble-minded is the principal reason for his commitment to the institution." Then, in a direct attack on one of the "scientific" arguments that had been used for two decades to support the argument for institutionalization of feeble-minded women, Fernald noted: "It is obviously not true that the majority of feeble-minded women bear illegitimate children." In summarizing the results of studies conducted in Springfield, Massachusetts and at the Rome Institution in New York, Fernald observed that many feeble-minded people who had been trained or educated had found good, steady jobs in the community and had manifested no "immoral or anti-social tendencies." And Fernald concluded: "The success of these people shows that we have not been quite fair in arbitrarily deciding that every feeble-minded person must be permanently deprived of his liberty, without careful study of all the circumstances in each case. To

admit this does not change the fact that in the majority of cases, with our present knowledge, the best way to protect the neglected feeble-minded person himself, and to prevent procreation, is under institution care."[86] At another point in his report, however, Hodgins quotes from a 1912 speech by Fernald, which Hodgins claimed Fernald had given him as "even now, his last word upon the subject." In that speech Fernald said: "The feeble-minded are a parasitic, predatory class, never capable of self-support or managing their own affairs.... Feeble-minded women are almost invariably immoral, and, if at large, usually become carriers of venereal disease or give birth to children who are as defective as themselves. The feeble-minded woman who marries is twice as prolific as the normal woman."[87] Exactly how Hodgins reconciled these two contrary opinions is not made clear. He also quotes from a statement by George L. Wallace, superintendent of the Wrentham State School in Massachusetts. According to Wallace: "The number of feeble-minded that can be safely cared for in the community is in direct ratio to the supervision that the community is willing to provide."[88] Yet this quite radical point of view is used by Hodgins merely to show that the extent of the danger from feeble-minded people had been exaggerated, and that it would not require an immense expenditure of public funds to provide sufficient educational and custodial facilities for the feeble-minded.

Unfortunately, the complete transcript of the actual testimony before Hodgins (which must have run to more than 800 pages) cannot be located, and so it is difficult to determine from the report itself exactly how Hodgins arrived at his conclusions, and even more important, what the various Ontario authorities thought about the problem at this time. It is interesting to observe that Dr. Harvey Clare, Medical Director of the Reception Hospital in Toronto and Medical Director and Assistant Director of the Ontario Government Institutions, expressed some skepticism about how widespread knowledge or fear of the feeble-minded was in Ontario. In discussing the term feeble-minded he noted: "It is not in my opinion a definite term.... I have come to the conclusion that some that are very low grade in some ways are high grade in other ways." When Hodgins asked if Clare did not believe that an exact classification could be made, Clare replied: "I was at one time, but I am away past that I fear. I began my life at the Orillia Hospital and lived there with the medical man in charge and took care of the patients there for a long time. Q. You do not now believe in it as you did? A. No, I have not the same confidence in my own ability to decide." Moreover, when Hodgins suggested that public opinion might force the government to establish a custodial institution in the northern part of the province, Clare expressed some doubt: "I do not think that it is public opinion.... There are certain urgent cases, isolated cases, the public care nothing about, in reference to whom the mayor and the hospital authorities and people of that kind write down and say, 'We have no place to send them here; what are we going to do? It is the people who are actually in control that are worrying about these

things, not the public at all'."[89] The fact that Dr. Clare's testimony was found in the correspondence files of W.D. McPherson, Provincial Secretary from 1916 to 1919, indicates that at least some of those who were skeptical about public acceptance of the idea that the feeble-minded were a menace may have got their ideas through those who directly influenced mental retardation policy.

Another curious aspect of the report is that although he includes evidence mainly from the U.S. showing that many feeble-minded people could remain in the community while attending special schools or special classes, and that they rarely posed a danger to themselves or to the community once trained or educated, Hodgins himself still leaned toward a custodial solution. Hodgins drew a sharp distinction between those feeble-minded people who should be institutionalized and those who should not. The former he refers to at one point as "dregs" and he observes that it is extremely important to distinguish between two classes among the mentally defective, "the comparatively harmless, and the anti-social."[90] This is why such tremendous emphasis was put on methods of identification and classification. Hodgins refers to "the necessity...for ascertaining at the earliest moment of a child's life whether it will become a ward of the State, and if so, to train and guard it so that it will not only receive the attention needed, but will be restrained from developing those qualities which inevitably result in 'fetching up' in court." Thus Hodgins recommends measures for the identification, registration and supervision of feeble-minded people in the province. "It is necessary," he claims, "to watch over the physical and mental development of the feeble-minded until the definite arrest of the mind takes place, and then to provide for its results. The whole object of state care and interference is to prevent the defect developing evil consequences to the body politic."[91] This notion of a public body watching people until this "arrest" of development takes place is, of course, laughable. But for Hodgins as for others who shared his views the resources of bodies as disparate as the Children's Aid Society, hospital mental clinics, public health departments, social service departments in cities and towns and the educational bureaucracy would all be marshalled in support of the process of identification and registration.

This entire line of argument was in keeping with some of the major assumptions of social theory at this time: first, that social problems were caused mainly by social problem people; second, that environment may have played a role in triggering anti-social responses but that social problem people had certain mental, moral or physical charateristics which differentiated them from normal people; third, that children who were likely to become social problem adults could be identified, and sometimes educated or trained to prevent the appearance of such behaviour; fourth, that social problem people comprised a certain percentage of every population (Hodgins refers to the "submerged tenth") on whom the attention and efforts of social service agencies should be focused; and fifth, that in

every group there were two sub-groups, those who were redeemable and those who were not.[92] Just as there should be separate institutions and policies for the curable and incurable insane, so too there should be separate policies and institutions for the young delinquent and the hardened criminal, the respectable poor and the lazy or immoral poor, and of course, for the educable feeble-minded and those who were ineducable. Thus, for Hodgins and the social reformers of the time, the extension of the special class system and the establishment of a custodial institution were the necessary components of a policy which should begin with the identification, registration, prognosis and, conclude, ultimately, with the treatment of feeble-mindedness.

To use a medical vocabulary here is to emphasize how important medicine was in defining and in prescribing treatment for mental retardation.

By World War I a new dimension had been added to the problem of feeble-mindedness as it became linked to venereal disease. Since contemporary statistics indicated that 60 percent of prostitutes were feeble-minded, the line became blurred between feeble-mindedness as an inherited condition and as a physical disease. For example, Justice Hodgins observed "no report would be useful unless it helped to arouse and quicken a public consciousness of the duty devolving on every social and governmental agency to aid in stemming the virulence of this hitherto unchecked evil. It is increasing and multiplying in such a way as to fill our criminal courts, gaols and penitentiaries, and even our charitable institutions with subjects whose defects are controllable if properly dealt with."[93] Studies at the Psychiatric Clinic at the Toronto General Hospital had found that "the questions of prostitution, illegitimacy, feeble-mindedness and venereal disease have bulked largely in the studies undertaken in the Clinic and it is clearly demonstrated that they are closely related — so much so, in fact, that they cannot be discussed intelligently apart. Prostitution is evidently carried on to a great degree by defectives, and as prostitution is the source of most infections in the case of gonorrhea and syphilis, it is evident that to segregate all cases of defective prostitutes will be an effective measure in helping to deal with the question of the increase in venereal disease."[94]

Feeble-mindedness had now taken on some rather curious characteristics. Many of those who were feeble-minded could not be distinguished from normal people, yet so pervasive were its effects, so serious its consequences that it seemed to account for some of the major social, and even physical problems of the age. However, a distinction was made between the curable and the incurable feeble-minded. If caught at an early age and sent to special schools, the former might be trained in such a way as to avoid becoming permanent social problems. But there would always be a certain percentage of feeble-minded people for whom nothing could be done. For them the only alternative was custodial care in large institutions where they would be segregated by sex and kept for the remainder of their lives. Given this perspective, it is difficult not to

compare the feeble-minded with victims of a mysterious plague. As with plague victims they were frequently indistinguishable from the normal population until the disease actually manifested itself. Perhaps the experts might detect the incipient signs of feeble-mindedness, but the average person, and even untrained physicians might be fooled. And once the disease broke out it was often too late, for so virulent were its effects that the only remedy was to immediately segregate the victim so as to prevent healthy people from being contaminated. Moreover, this particular plague was hereditary, being passed on from mother to child. Even more horrifying was the fact that the victims tended to have more children than normal mothers. Only if feeble-minded women were prevented from having children could the plague be stamped out.

Thus, after World War I in Ontario, there was a certain conceptual blurring so that at times feeble-mindedness was discussed not as a social or moral problem, nor as a physical condition, but as a physical disease to be dealt with through the mechanisms of public health. Justice Hodgins observed: "One thing is made clear to me by my enquiries: it is that the present interest in the question of the mentally defective, both here and elsewhere, arose as the direct result of the growth of preventive medicine, the principle underlying which stimulated alienists as well as other physicians. It cannot be said to be due to a recognition of the evil as a social problem. It follows that its apostles are chiefly medical men who have studied psychiatry and psychopathy and those whom they have interested in their discoveries. But these alienists are few in number and the bulk of the medical profession know little about mental defect."[95]

The reasoning in this statement is a bit confused. Hodgins was certainly right in saying that most medical doctors knew (or cared) little about mental retardation. But in arguing that interest in mental retardation was linked to the rise in preventive medicine rather than acknowledging that it was a social problem he ignored the fact that preventive medicine for mentally retarded people really meant establishing certain kinds of social, not medical, policies to reduce the incidence of the "disease." Of course, it was in the interest of doctors and psychiatrists to argue that mental retardation was primarily a disease, since many of them had achieved administrative posts at the head of institutions, in government, or had won scholarly reputation because it was generally accepted that the medical profession had a certain expertise in "treating" mentally retarded people. It is this which explains the curious way in which medical categories were used as a basis for prescribing social remedies.

For example, medical doctors spent an immense amount of time on the nosology of mental retardation, as if the mere classification of one or another aspect of mental retardation provided a guide to correct treatment, and ultimately, policy. Under the influence of the medical model, one simple, but crucial distinction stands out. It was assumed that mentally retarded persons could be divided into two categories, the "harm-

less" (i.e., the curable) and the "anti-social" (i.e., the incurable). Once this distinction was agreed upon it was an easy matter to derive separate policies for each group: special classes or schools for the first, custodial institutions for the second.

However, given the very serious consequences that would ensue, how was one to make the crucial diagnosis of incurable feeble-mindedness? On this point Hodgins was reluctant to recommend any measure that might be inaccurate. For example, the IQ test would seem to have been a possible instrument to use, but the results obtained by the U.S. Army during World War I were ambiguous. In a famous experiment, the Army had administered the test to 1,668,000 recruits but had found, to everyone's horror, that the average mental age turned out to be between thirteen and fifteen years. As a result many people questioned the validity of an IQ test, but some, among them Hodgins, drew different conclusions. One authority Hodgins had spoken to accepted the tests noting that the average was not a bad one, since a mental age of even eleven years was considered a self-supporting one.[96] Hodgins agreed with this view, adding that "many mentally defective men drafted into the army were apparently normal, not actively anti-social, and perhaps self-supporting. In the United States use was made of many who, judged by strict medical standards, were mentally defective. And that this is the case in civil life cannot be doubted, for much of the rough and heavy work of the world must be, and is in fact done, by those who are somewhat below the normal.... In dealing practically with the detection and care of the feeble-minded, great caution must be observed so as to avoid indiscriminate condemnation."[97] On the other hand, Hodgins noted that the IQ test could not by itself form the basis of a decision about mental deficiency. Rather, he agreed with MacMurchy that such a diagnosis should not be made lightly, but only after intensive observation. Thus, after teachers, social workers, the police and others had selected those likely to be suffering from mental deficiency and brought them to the attention of a provincial mental health authority, the individual would be intensively studied by a psychiatrist and a nurse "for a week or more, in some one school, in order to properly determine whether the individual should continue in the special class or be at once removed to an institution."[98] Moreover, Hodgins also suggested that the school law be amended requiring parents to submit their children to medical examinations for mental deficiency, and forcing children found below normal to attend special classes.[99]

In the end the Hodgins report turned out to be a mixture of contradictory opinions and findings about mental retardation. At some points Hodgins seemed to feel that the feeble-minded could best be cared for in the community, either by their families or with the aid of social workers, while at other times he seemed to be arguing for the custodial view. But in his final twenty recommendations, he endorsed every proposal that had been put forward by the social reformers over the preceding de-

cades, as well as adding a few of his own.

In Hodgins' view, existing policy was incomplete since it did not take account of two crucial factors: first, the absolute necessity of identifying mentally retarded children and separating the harmless among them from the anti-social, and second, the lack in Ontario of a custodial institution for the feeble-minded. Thus, Hodgins proposed that a survey be taken to determine the identity of mentally retarded people, that these people then be registered and that their condition be diagnosed. He also proposed that a board of control or a departmental committee under the authority of the Provincial Secretary be established, including members from the major social reform groups such as the Children's Aid Society, the Canadian National Committee on Mental Hygiene and the PACFM. This body would supervise the carrying out of the survey and the process of identification and diagnosis. He also recommended the appointment of an "Inspector for Mental Defectives or for the Feeble-Minded" who would be attached to the Provincial Secretary's Department. Why Hodgins made this recommendation is not clear, unless he already knew that Helen MacMurchy, who was then Inspector of the Feeble-Minded would be leaving to take a job in the Division of Child Welfare in Ottawa. Hodgins also recommended that a Psychopathic Hospital be established in Toronto as well as in other urban areas in the province. Its objectives would be to examine suspected cases of mental defect and then to recommend further treatment. He also recommended "more adequate provision for the permanent segregation of feeble-minded women of child-bearing age" where they would be under permanent detention.[100] "Consideration should be given to the practicability of establishing laundry colonies near large cities and towns...similar to those planted by Dr. Bernstein in Rome, New York."[101] Boards of education would be compelled to establish special classes for the mentally retarded, and parents would be obliged to send their children to these classes. He also recommended enforcement of a requirement that immigrants take "mental tests"; the passage of federal and provincial legislation forbidding the marriage of mentally defective or feeble-minded people, as well as legislation imprisoning anyone who "knowingly and wilfully marries or has carnal connections with a person who is mentally defective so as to prevent, during the term of imprisonment their further procreation of children who may be feeble-minded."[102]

The Hodgins Report and the Collapse of the PACFM

Hodgins presented his report on October 18, 1919. Most of his recommendations were ignored. A board of control was never established, a provincial survey of mentally retarded people was never carried out, a custodial institution specifically for the feeble-minded was not established and after MacMurchy left for Ottawa in 1920, the post of Inspector of the Feeble-Minded disappeared. Except as regarded regulations governing marriage between mentally retarded people the province con-

tinued to work variations in existing policy.

One of the reasons for the lack of any major change in policy was that in November, 1919, the United Farmer government of Ernest C. Drury replaced the Liberal government of W.H. Hearst. Although special classes for retarded children were gradually assuming increasing importance, by far the major responsibility in mental retardation policy still rested in the hands of the Provincial Secretary. But the new Provincial Secretary, H.C. Nixon, who replaced the outgoing W.D. McPherson was not particularly sympathetic toward the social reformers.

With MacMurchy's departure for Ottawa, the PACFM had disappeared and been replaced by a new organization called the Canadian National Committee for Mental Hygiene, founded on April 26, 1918. The CNCMH quickly emerged as the leading pressure group in the area of mental health and mental retardation. But the biographer of Dr. Clarence Hincks, the founder of the CNCMH, speaks of Provincial Secretary Nixon's "uncooperative and unfeeling attitude toward the CNCMH," an attitude which was probably a reaction against Hincks' angry attacks on government inaction in the field of mental retardation. For example, at a meeting of the Ontario Educational Association on April 7, 1920, furious at the lack of government response to two decades of pleading from the social reformers, Hincks said: "Ontario is far behind in mental diagnostics. The government says 'Don't knock your own province.' Why we have enough facts to blow up the Parliament buildings!" Both Howard Ferguson, the Leader of the Conservatives, and Premier Drury condemned Hincks' statement, but Hincks obtained a meeting with Drury through the good offices of J.E. Atkinson, publisher of the Toronto *Star*. Hincks is reported as saying: "I gave this group the entire story of the almost criminal neglect of cases of mental disability in Ontario. Mr. Nixon was asked by Mr. Drury if my points were correct. He replied that they were. Then Mr. Drury said, 'My government owes you an apology'."[103] Still, the government made no move toward elaborating the comprehensive policy recommended by Hodgins.

Certainly the collapse of the PACFM and MacMurchy's absence were major blows to the social reformers. For fourteen years MacMurchy had written annual reports on the feeble-minded for the Provincial Secretary, but unlike so many government documents, these were widely read and quoted. And from 1914 to 1920 she held the official post of Inspector of Auxiliary Classes and from this position she had further publicized the issue of mental retardation and had launched the appeal for the formation of special classes. During the period from 1905 to 1920 she had enlisted the most important social reform groups in the province in the struggle for special education and custodial care and, from her position in government she had obtained the sympathy and even the support of successive Provincial Secretaries from W.J. Hanna to W.D. McPherson. But just when the Hodgins report was published, she left the struggle. Whether the PACFM collapsed because MacMurchy was the keystone in the

edifice, or because, as a single-issue pressure group, it had lost its élan as the movement for reform widened to encompass mental health, is not clear since no records of the PACFM can be found.

Of course, the CNCMH tried to carry on the struggle but its efforts were divided between the field of mental health, which was its real interest, and mental retardation. The CNCMH had been founded by Dr. Clarence Hincks, a Toronto psychiatrist who had been appalled at the lack of understanding of mental illness among Canadian physicians. After reading Clifford Beers' *A Mind That Found Itself,* he tried to organize a mental hygiene committee in Canada much along the same lines as Beers had done in the U.S. On a visit to Montreal in early 1918, he met with the medical faculty at McGill University, and explained the need for a national organization to conduct surveys on the extent of mental illness and to promote better training and research. He got overwhelming support for his project. From Montreal he went to Ottawa where he called on the Governor-General, the Duke of Devonshire. Once again he was amazed to get the Governor-General's immediate agreement to sit on the board of directors. After this, it was easy to recruit some of the leading businessmen and academics in Canada to the board, including Lord Shaughnessy, President of the Canadian Pacific Railway, E.W. Beatty, Vice-President of the CPR, Sir Vincent Meredith, President of the Bank of Montreal, W. Molson, President of Molson's Brewery and others. Finally, the board elected Dr. C.R. Martin, Professor of Medicine at McGill, as president, E.W. Beatty as chairman, Dr. C.K. Clarke as medical director, Miss Marjorie Keyes as social worker and Hincks as associate medical director and secretary — the same position as was held by Clifford Beers in the U.S. At its inception practically the entire executive of the Toronto branch of the PACFM — MacMurchy, Clarke, Mrs. A.M. Huestis, Professor Peter Sandiford from the Psychology Department of the University of Toronto, and Dr. Gordon Bates — became members of the CNCMH. And of the thirty-seven members of the CNCMH from Toronto in 1920, almost half, seventeen, had previously been members of the PACFM. Thus there was a good deal of overlap between the PACFM and the CNCMH in the early years of the organization.

Although the CNCMH took up where the PACFM had left off, and continued to pressure the government to provide funds for additional custodial institutions, the government resisted. And the reasons remained the same. Social policies can be costly or costless. While the government had partly acceded to the wishes of the reformers by altering the statutes regarding houses of refuge and industrial refuges for women, giving physicians the power to refuse release to feeble-minded women and giving them power as well to transfer feeble-minded women to Orillia, these measures did not require any additional funds.[104] Even the decision to establish special classes for the feeble-minded had not yet placed a serious burden on the provincial treasury since local boards of education

were reluctant to provide the necessary funds. Moreover, since 1890 there had been a continuing decline in provincial public expenditure on asylums, a decline which had sharply accelerated after 1916. In frustration, Dr. Hincks complained to the Social Welfare Congress on January 14, 1919:

> Deputations have gone to the Provincial Parliament Buildings annually for about twenty years. I, myself, have made the journey five or more times. We have told our story to the Cabinet. What has been our reception? Invariably during the last five years at least, a most courteous one. What has been the attitude of members of the Cabinet? As a rule a sympathetic understanding of our problem from the Premier down. Then why haven't we got results? Because I take it that reforms would cost money, and because the governments have received no special mandate from the electors to spend money for such reforms.... What then must we do in Ontario and other provinces of the Dominion? We must make the feeble-minded problem an election issue.[105]

Hincks' sentiments notwithstanding, the feeble-minded did not become an election issue, although both the Ontario and the Canadian governments continued to make statutory changes, as in revising the immigration laws so as to forbid the admittance of mental defectives to Canada, or imposing a prison sentence on anyone issuing a marriage license to idiots or the insane.[106]

It would be nice to add that humanitarian sentiments were also expressed by various people concerning the treatment of mentally retarded people. But there is little evidence that anyone prominent in the social reform movement held the same opinions as Josiah Wedgwood, the radical MP from Newcastle-under-Lyme who had argued so eloquently against the philosophy that underlay the 1913 English Mental Deficiency Act.

In the end, then, the explanation for the fact that the provincial government did not elaborate a comprehensive policy for the feeble-minded must be expressed in problematic terms: a top civil servant social reformer leaves Toronto for Ottawa; a pressure group dies; a government puts its financial priorities on policies outside the mental health or mental retardation field; and one premier is replaced by another. It might easily have happened quite differently, and in fact it did elsewhere. In England the Mental Deficiency Act of 1913 was passed; on April 17, 1919 the Province of Alberta adopted an "Act Respecting Mentally Defective Persons," granting the province power to institutionalize mentally defective persons even against their parents' consent.[107] And, throughout the U.S., especially in the northeast in New York, New Jersey, Pennsylvania, etc., custodial institutions, some specifically intended for feeble-minded women, were established during the latter part of the nineteenth

and early twentieth centuries. However, Ontario was reluctant to build any new custodial institutions or to sharply revise its policy. Thus, Orillia was to remain the major institution for mentally retarded people until Smiths Falls opened in 1951.

The Internal Economy at Orillia

Perhaps one additional reason for the province's reluctance to embark on a construction program was that Orillia had been thought of as a custodial institution from its very inception in 1876. This was quite unlike the early American institutions which had begun as schools for mildly retarded persons and had been gradually pushed toward the custodial model under pressure from families and government. While the American institutions were converting schools into dormitories, or adding custodial wings to the schools, A.H. Beaton was fighting to add some sort of educational facility to Orillia. But by the end of the nineteenth century with custodialism in vogue, Beaton too began to repeat the same kind of arguments that had been used in the U.S. After the Association of Officers of American Institutions for Feeble-Minded Persons met at Orillia in July 1897, Beaton wrote: "Questions relating to the care and training of the feeble-minded and the best methods for bringing the claims of this unfortunate class before the respective governments were discussed and passed upon. The causes that lead up to this degeneracy in the race, and the best methods to lessen the evil also received attention."[108] By 1902, Beaton was advocating the construction of two additional cottages for the "custodial care of feeble-minded women of child-bearing age," since the "six or seven hundred feeble-minded women" in the province added to the "idiotic and otherwise defective population of the Province." According to Beaton, confining them in a custodial asylum would lessen the number of "defectives, paupers and petty criminals."[109] By 1913 construction work began at Orillia on a 150-bed cottage for women, followed the next summer by work on a 150-bed cottage for men. The latter was completed in October 1917. Given the continuing pressure for space it is likely that new facilities would have been provided even if the social reformers had not agitated for additional accommodation. But the coming of World War I led the province to transfer 150 insane women from Whitby to the new women's cottage at Orillia so that Whitby could be used as a hospital for wounded servicemen.[110] The fact that the end of the war meant that a cottage at Orillia would once again become available for mentally retarded people was probably another reason for provincial reluctance to use funds for establishing a new custodial institution.

One of the ironies of the history of Orillia is that though they were counted as idiots in the statistics, many of the inmates were not mentally retarded at all. From the very beginning, Orillia had been used as a dumping ground for the old, senile, the poor, or the noisy, troublesome, delinquent, indeed, for practically anyone who could be fobbed off by private individuals or other provincial institutions. Since Orillia was a dead-end

institution in that it was exceedingly difficult to transfer someone out once admitted, the inspector and the medical superintendents had to deal with a large group of people who were clearly not retarded. But the institution made use of this fact by classifying inmates according to two different sets of criteria. The first, or medical classification was applied to new admissions and conformed to contemporary medical terminology. This system of classification appeared in the various institution reports, and served to confirm the manifest role of Orillia as a custodial institution for mentally retarded people. Thus, inmates were classified as "idiots," "imbeciles," with, later adjectives such as "low," "medium," or "high grade" attached to the generic term. On the other hand, when it came to the internal demands of the institutional economic or social system, a second, informal set of criteria were used. A good example of this can be found in A.H. Beaton's report for 1897. Here Beaton shifts between medical and socio-economic terms without noticing the ambiguities:

> One thing is certain, we cannot long resist the demands of the public for increased facilities for caring for idiots and imbeciles. It is unfair to those who are unable to get relief. Nothing is more sad than a poor family with one, two, or three idiot children. Separate provision is being made for epileptics in many of the American States as well as in Europe.... Another method for meeting the demands of applicants would be to erect two cottages, which need not be expensive, where the useless men and women could be housed and cared for at minimum expense. And a third plan would be to purchase farm land and erect a farmhouse which would accommodate 40 or 50 working patients...a house should be built for the medical superintendent turning that portion now occupied by him into the institution, which would provide for at least forty children.[111]

Jumbled together are "idiots," "imbeciles," "idiot children," "epileptics," "useless men and women," "children," and "working patients."

By the turn of the century, therefore, the work of the inmate was an essential part of the asylum economy, and superintendents everywhere made distinctions among residents on the basis of their ability to contribute to the asylum or workshop. Another example of this kind of categorization comes from the report of J.P. Downey who replaced Beaton in 1910. Writing about the plan to construct two cottages for men and women, Downey said: "With our new cottages completed we shall be able to better classify our population and separate the improvable from the custodial cases. The main building, capable of accommodating 400 boys and girls can then be devoted exclusively to the work of a training school for the children, while the four cottages, each with a capacity of 200 [later reduced to 150] will house the workers who have grown beyond the improvable stage, the old people and the low grades."[112] For Downey, therefore, age and the ability to work at the institution were the

two main criteria which would determine where the inmate would be housed. Moreover, the term "improvable" had a particular meaning for Downey, for he writes:

> The chief end and purpose of the training of the feeble-minded child...should not be to fit him for a place in life but to increase his happiness and make him of the greatest possible service to the institution in which he must ultimately find a home.... The closer the training school approaches and the more fully its training comprehends the practical management of a self-sustaining institution, the more enduring success will attend its operations.... What I am contending is that efficiency in the practical, everyday departments of an institution should be the great desideratum: all other things, helpful, desirable, attractive though they may be, should follow.[113]

No wonder Downey boasted that he had increased the workforce at Orillia by over 300 percent in three years.

Thus, Downey's main concern seemed to be less whether prospective inmates were really mentally retarded, and more whether or not they were good workers. He complained bitterly when other institutions tried to send him the senile, old or "useless," but he boasted about the fact that so many of the girls sent to Orillia from the Children's Aid Society in 1917 were good workers. "The history and environment of most of these cases before their admission had been bad. Some of them were absolutely unmanageable. We were enabled to report that all of these patients are doing well, engaged in useful and improving work.... 'A' was described in the form at the time of admissions as 'stubborn, secretive, unmanageable, immoral and a trouble maker.' The last report in reference to this girl says: 'She has become, with occasional relapses, a very useful worker in the laundry where she exercises considerable care in her work'."[114] Did "A" or her sister "B" who Downey says learned to read and do handicrafts "with a promise of considerable further improvement" spend the rest of their lives in Orillia? We do not know, but, according to Marion Harvie, a teacher at Orillia during this time, some of the inmates, particularly those sent from the Children's Aid Society were close to normal intelligence.[115]

Under both A.H. Beaton and J.P Downey the percentage of those discharged each year varied between 1 percent and 2 ½ percent of the total population. In view of the changing age structure and intelligence level of those admitted year by year the variations are insignificant. Moreover, it is unclear why people were discharged as "improvable" or "unimproved." Some of these discharges may have been at the behest of parents or relatives, rather than because the superintendent believed in returning inmates to the community.

Even when parents requested the release of their child, they might run into opposition. For example, on April 14, 1899, A.H. Beaton wrote to

a mother explaining that her daughter could not be released since she had been sent under warrant from the Lieutenant Governor. "I do not think the Government would consent to allow J. or any other girl of feeble mind to be taken out unless there is the most positive assurance that she would be provided with a suitable and safe home, where her life and actions would be under constant surveillance...you must understand that she is not at all fit to go out to service or do anything for herself. She is too simple-minded for that, although she is a sweet, amiable girl."[116] Thus, by the turn of the century, like his colleagues in the U.S., Beaton had begun to think of Orillia as a closed system. By 1902 he no longer tried to justify educating the inmates to help them become self-supporting, but rather talked about making the inmates useful about the institution or even of becoming useful inmates of other institutions.[117] And in 1907 Beaton complained in a letter to Reverend J.A. MacDonald that he had not been recognized as among the first in Ontario to advocate care and protection of feeble-minded women in an earlier speech he had given to the Children's Aid Society in 1898.[118]

J.P. Downey seems to have been particularly keen on linking the internal economy of Orillia with other provincial institutions. He thought of provincial institutions as composing a corporate system, whose specialized needs would be served by the individual institutions. In 1923, Downey suggested that Orillia develop "a line of industries that would not be beyond the capacity of our children" to supply the needs of the other provincial institutions.[119] By 1925, Orillia was supplying other institutions with shoes and clothing for Downey mentions that not only did he hope to see the sixteen boys in the shoe shop turn out from 25 to 50 pairs of shoes a day, but also that Orillia had already filled orders from other institutions for uniforms, shirts, socks and caps. The shoe industry at Orillia seems to have been particularly productive for statistics show sales of up to $14,802 for 305 dozen pairs in 1932, while even in 1941 sales of shoes for that year were valued at $10,425.[120] Downey also mentions that tweeds from the Guelph reformatory were used to make clothing at Orillia.[121]

Even the school at Orillia, which had closed during 1903, was to be used to serve the internal economy of the asylum. In his 1921 report Downey recommends enlarging the school by adding new departments and new teachers not because the inmates were to be educated to return to the community, but because "the ability to read and write and count or become proficient in any of the industrial departments means increased usefulness and consequently greater happiness for the child and greater service on the part of the children of the institution in which nearly all of them must find a permanent home."[122]

In 1922 Downey was expressing his gratification at the fact that the products of Orillia "are entering more largely as time goes on, into the daily service of this and other provincial institutions."[123] In 1925 Orillia had the lowest per capita maintenance costs of all the provincial asylums.

There also seems to be evidence that under Downey Orillia was used by the Connaught Laboratories in Toronto to test new drugs. In his report for 1925 Downey notes that Orillia had been visited by several epidemics during the year. Downey then called the Connaught Laboratories which was investigating the Dick test and scarlet fever antitoxin. One thousand and eighty tests were made, with 297 positive reactions to which the experimental immunization was then applied. "The subsequent observation of this work proved a factor in the standardization of the protective dose of scarlet fever antitoxin, a matter of inestimable public importance." Downey does not say whether the parents of the inmates were consulted. By contrast, when a diphtheria toxoid test was made of Toronto school children in December 1926, parents were first asked to give their written consent.[124]

Mentally Retarded Persons in Houses of Refuge

While the social reformers were agitating for a new policy toward the feeble-minded, and while Orillia was becoming ever more set in the custodial mode, the government was putting increasing pressure on the municipalities to establish local institutions to cope with the growing number of social problem people. In 1903 the province passed an act compelling the counties to erect houses of refuge.[125] In 1913 a new act again required the counties to erect houses of refuge allowing the counties to appropriate the funds with the consent of the voters.[126] In 1906 the province amended the Supplementary Revenue Act of 1899 so that municipalities were charged ten cents a day for patients from the municipality sent to the provincial asylums. Thus, whereas in 1899 there was a total of nine municipal houses of refuge, houses of industry or poor houses, by 1914 there were seventy-one refuges and homes of various kind receiving provincial support. They had among them a total of 7,986 inmates. This number was very close to the total number of insane and mentally retarded people in the provincial institutions.[127] Thus, local responsibility for the insane, retarded, senile and other groups only became part of formal government policy by the turn of the century. The fact that local jails housed social problem people until this time was accidental, and not the result of a deliberate policy decision. Indeed, it was because of local pressure that the provincial government had established provincial institutions to house the insane and retarded. It was only after the pressure to gain admittance to these institutions became unbearable that for the first time the counties were forced to erect local institutions. This was in direct contravention of the firmly held opinion that local institutions would inevitably fall short of provincial standards of care. Certainly, conditions in the houses of refuge were worse than at Orillia, but the various refuges seem to have played the same game as was played at all the provincial institutions, for they tried to keep those inmates who could help in the internal economy of the institution, or who caused the least trouble, while fobbing off the senile old, the work-shy, or the troublesome onto Orillia.

In 1917, when she was an Assistant Inspector of the Feeble-Minded under the Provincial Secretary's office, Helen MacMurchy reported that a number of matrons of various houses of refuge had trained mentally retarded inmates as household assistants. She also noted that one matron reported that fourteen out of seventy inmates were mentally defective in her house of refuge, while others reported figures as high as 50 percent.[128] Thus the houses of refuge contained a mixed bag of people, some of them mentally retarded, others not. But one common assumption about local institutions was correct, invariably the inmates received a much lower level of sustenance and care than those in provincial institutions. In 1910, for example, the Inspector of Hospitals complained: "Those in charge of the Houses of Refuge in most counties are honestly endeavouring to do their best, but they are often hindered in their efforts by the determination of the County Council to have the House conducted at the lowest possible cost."[129] In 1912 the inspector found that in one of the wealthiest counties in Ontario the roof leaked so badly in one house of refuge that when it rained the inmates were forced to get up and move their beds, while in another, one room in the basement served as a sitting room, smoking room and dining room.[130]

Conclusion

From 1900 to 1920 mental retardation policy became more complex. Special classes for mentally retarded children had been started, while municipal houses of refuge and houses of refuge for females took in increasing numbers of mentally retarded people. Dominating the scene, was Orillia, an institution housing 983 people in 1920. However, despite the efforts of the various social reformers in the PACFM and then later in the CNCMH, there is little evidence the government tried to elaborate a coherent mental retardation policy. During this period, as before, the government followed a largely ad hoc, uncoordinated method of dealing with each problem as it arose. As backward students or slow learners appeared in the public school system auxiliary classes were established and gradually extended. As Orillia began to burst at the seams with inmates, the municipalities were forced to establish local institutions, and as the total expenditures for Orillia continued to mount, the inmates were put to work serving the internal economy of the institution. Decision making policy as regards mental retardation was based on incrementalism, that is, policy tended to "identify situations or ills from which to move *away* rather than goals *toward* which to move."[131] Certainly the interests of mentally retarded people were of little account in provincial decision making. The entire structure of mental retardation policy was dominated by a government whose primary concern was to meet public demand for space with the cheapest possible service. None of the pressure groups spoke in the interests of mentally retarded people. Their interest was in solving other social problems through the means of mental retardation policy. Georg Simmel has put this point quite well in writing about assist-

ance to the poor:

> As soon as the welfare of society requires assistance to the poor, the motivation turns away from this focus on the giver without, thereby turning to the recipient. This assistance then takes place voluntarily or is imposed by law so that the poor will not become active and dangerous enemies of society, so as to make their reduced energies more productive and so as to prevent the degeneration of their progeny. The poor man as a person and the perception of his position in his own mind, are in this case as indifferent as they are to the giver who gives alms for the salvation of his own soul.... The fact that the poor receive alms is not an end-in-itself, but merely a means to an end.[132]

Although the period after the release of the Hodgins report saw renewed efforts by social reform pressure groups to extract some kind of coherent policy from the government, by the 1930's mental retardation began to move from the centre of the political stage and lapse into obscurity. The myth of the menace of the feeble-minded was beginning to disappear, but there was nothing to take its place. Gradually mentally retarded people would cease to be the means to larger social policy ends. By the 1930's they would become merely awkward and potentially expensive objects of a policy which seemed to have no other goal than to remove them from the community and house them as efficiently, as cheaply and with as little fuss as possible.

Amidst this flux in policy, however, it is possible to discern one persistent tendency — the attempt to distinguish between those who should, and those who should not be institutionalized.

Too often historians have implied that the late nineteenth and early twentieth century was completely dominated by the custodial movement and by custodial institutions, and that the movement toward community care only began after the Second World War. In fact, those associated with mental retardation policy always tried to distinguish between two groups of mentally retarded people: those who needed institutional care because they were unable to cope with life in the community, or because they were a social menace; and those mentally retarded people who could be educated or trained to take their place in the community.

Thus it was never argued that all mentally retarded people should be institutionalized. Rather, the lines were constantly being drawn and redrawn according to changing definitions and interpretations of mental retardation, and according to changing social conditions. During the latter part of the nineteenth century in the northeastern United States, and in Ontario after 1911, special classes or special schools were opened for mentally retarded children who might remain in the community. Of course, these schools and classes were expected to fulfill a dual purpose,

to educate children — and to identify candidates for institutions. But distinctions were always made for not everyone was slated for the institution. Later as the myth of the menace of the feeble-minded gathered steam, new lines were drawn, new distinctions made and new interpretations of mental retardation elaborated. But the vast majority of mentally retarded people never saw the inside of an institution, and although no accurate figures are available it is likely that even the majority of mentally retarded people who came to the attention of the authorities remained in the community. The late nineteenth and early twentieth centuries may not have talked in terms of community care, but mental retardation policy during this time was not monolithic. By contrast we will see that even during the height of the deinstitutionalization movement, and the attempt to integrate mentally retarded people into the community, large numbers of people continued to find their way into the institutions, while the institutions themselves fought back vigorously against all attempts to undermine their role. It is true that we now talk quite explicitly about normalization and community integration, but we should not let our infatuation with the contemporary vocabulary of mental retardation policy blind us to the fact that policy has always been complicated, always composed of a number of different strands, always intended to serve a number of purposes.

5

The Failed Attempt at Deinstitutionalization

One of the reasons for the decline of the myth of the menace of the feeble-minded was that new ideas about the nature and social implications of mental retardation were beginning to filter through and to call into question some of the assumptions that sustained that myth. Perhaps one of the major assumptions concerned the hereditary nature of mental retardation. As Walter Fernald said in 1918: "The proven hereditary origin of so many cases of feeble-mindedness is, of course, the principal reason for wholesale segregation."[1] On January 28, 1925, however, Dr. Clarence Hincks, founder and executive secretary of the CNCMH delivered an address to the Social Service Council of Canada called: "Recent Additions to Our Knowledge of Mental Deficiency." Drawing mainly on Stanley P. Davies' book *Social Control of the Feeble-Minded,* Hincks summarized the new evidence about mental retardation. He began with a *mea culpa.* Noting that in a 1919 article (published in *Social Welfare*) he had stated that about 80 percent of mentally retarded people came from "unsound stock," he now admitted that recent studies showed that less than 50 percent of feeble-mindedness was inherited. The famous studies of the Jukes by Dugdale and of the Kallikaks by Goddard were faulty since they drew their sample from mentally retarded people in institutions, whereas samples drawn from the community showed a much smaller proportion of feeble-minded people with feeble-minded parents. "Perhaps the most truthful statement that can be made at the present time about the relationship of heredity to feeble-mindedness is that we know less than we thought we knew." But, Hincks concluded, if with some degree of certainty one could identify those people who did pass feeble-mindedness on to their children, then, "under careful safeguards" legisla-

tion for sterilization should be enacted.

Hincks also attacked the exclusive use of IQ tests for determining whether or not a person was feeble-minded. He pointed out that the U.S. Army tests during World War I indicated that 50 percent of U.S. Army draftees had a mental age of less than thirteen years, and therefore, by prevailing definitions, were feeble-minded. "But," said Hincks, "the real test of mental deficiency is the social test. If an individual cannot get along in the community — if he cannot compete on equal terms with his normal fellows [here Hincks was using a definition that had been adopted in the English Mental Deficiency Act of 1913] — if he cannot conduct his affairs with ordinary prudence and if he has a mental age of less than twelve years — then it is probably safe to say that he is feeble-minded." Using these two criteria, IQ tests plus social competence, Hincks estimated that only .6 percent of the Army draftees had been feeble-minded. He emphasized, however, that more than an IQ test was necessary to adduce feeble-mindedness, and he pointed out that: "A man may have a mental age of ten and yet be a splendid worker, a good citizen and a reasonably good father.... It is therefore important...to determine not only the degree of intelligence, but to investigate such traits as laziness or industriousness, carefulness or carelessness, ambition or lack of it, social adaptability or its absence and so on."

Of course, these arguments explicitly called into question the assumption that most feeble-minded people needed custodial care. Hincks admitted that the estimated $60,000,000 required for the custodial care of the 60,000 cases of feeble-mindedness in Canada was inordinately expensive, and he added that there was good reason to suppose that a large percentage of feeble-minded people could find a place in the community. "The most outstanding discovery of the last ten or fifteen years...is the fact that, if the feeble-minded are discovered when they are young and if they are given suitable methods of training in special classes in public schools, and if they are assisted in finding suitable work and if they are given reasonable encouragement and supervision — it is found that the majority will give no trouble to society." As evidence Hincks cited a study of feeble-minded children who had been students in special classes in Cincinnati, Ohio. It was found that of 201 cases over 60 percent had jobs while only 22 percent had court or institutional records. As for the length of time feeble-minded people had to be institutionalized, Hincks quoted Walter Fernald who had found that over a twenty-five year period "a very small portion of the discharged male morons had committed crimes, or had married, or had become parents, or had failed to support themselves, or had been bad citizens." Most important Fernald found that "a surprisingly small number" of females who had been discharged from the Waverley, Massachusetts institution had either married or become mothers. Hincks then concluded on an optimistic note: "We are beginning to realize that, if society takes the trouble to provide healthy surroundings for these defective individuals, the majority will not give

trouble. If we fail to provide such needed facilities as mental clinics, special classes in public schools, supervision in the general community and other measures, the problem of feeble-mindedness will remain as one of the chief obstacles to social betterment."[2]

A number of important facts emerge from Hincks' speech. First, sociological studies of the actual facts surrounding the linkages between feeble-mindedness and social problems had disclosed the gross errors that lay behind the menace of the feeble-minded argument. Second, statistical studies of the genetics and the hereditary nature of mental retardation were undermining one of the major, perhaps the key argument for compulsory institutionalization of feeble-minded women, namely the assumption that feeble-mindedness was a condition inherited from a feeble-minded parent. Third, social reformers concerned with mental retardation saw no inconsistency in arguing a case which combined benign measures such as returning mentally retarded people to the community, with punitive measures such as compulsory sterilization of feeble-minded women.

Despite the fact that Hincks' speech was a serious blow to the "scientific" assumptions which lay behind the social reformers' policy proposals on mental retardation, the CNCMH and other pressure groups continued to ask the government to establish additional institutions for the feeble-minded, especially for those who were not under the aegis of existing programs. The Social Service Council of Ontario was particularly prominent in this campaign, which is not surprising since many of its members most interested in mental retardation were ex-members of the PACFM. Reverend Peter Bryce headed the child welfare committee of the Social Service Council in 1920, while in 1926 a committee established to study and make recommendations on the treatment of the feeble-minded was headed by another ex-member of the PACFM, Dr. F.J. Conboy and included as well Drs. T.R. Robinson and Margaret Patterson, all from the PACFM. In 1927, the Social Service Council met with the CNCMH, the Association of Children's Aid Societies and the Women's Institutes of Ontario and made a series of recommendations to the government concerning the feeble-minded. The recommendations reflected the diverse concerns of the different pressure groups as well as contemporary thinking about how best to deal with the problem. For example, they again asked the government to take up the Hodgins report and to establish additional custodial institutions. They also proposed the establishment of a school and industrial training building, plus colonies for "tractable, able-bodied patients over sixteen years of age."[3] In view of the fact that Orillia was forbidden to take children under the age of six they suggested that a hospital for children under six be established, plus buildings for 100 "working boys of lower grade intelligence" over the age of sixteen and too old to attend school. It was assumed that the institutions should be self-financing, since the "patients" would be "working or able-bodied."

Another major proposal was that a school for 1,000 teachable mentally

retarded people be established "as a complete clinic for physicians, medical students, nurses, teachers and social workers and others." This was an entirely new idea and was inspired by the notion that the growing number of medical and social service personnel who were dealing with mentally retarded people should have an opportunity to get specialized training. A third set of proposals, mainly inspired by the CNCMH asked that a psychiatrist be appointed to act in an advisory capacity to the government on planning services to the mentally ill and mentally retarded, and that a psychiatrist be appointed as superintendent, and a woman doctor to the staff at Orillia. And a fourth proposal was that some provision should be made to help patients "move out into the community with supervision and to return to the institution without re-commitment if there is a failure in social, moral and economic adjustment."[4]

Whatever sympathy the Ferguson Conservative government might have felt toward these recommendations it was no more ready to expand the number of institutions for the mentally retarded than was Drury's United Farmer government from 1919 to 1923. The major concession Ferguson made was to establish a Royal Commission on Public Welfare in 1929, chaired by P.D. Ross with D.M. Wright and J.M. McCutcheon as Commissioners.

The 1929 Royal Commission on Public Welfare

Appointed to inquire into the provincial hospitals, asylums and other public institutions, the commission returned an extremely harsh series of recommendations on mentally retarded people going far beyond the kind of punitive measures suggested even by groups as impressed by the menace of the feeble-minded as the PACFM. The commission endorsed every existing proposal for extending institutional care for mentally retarded people, and then added one that had hitherto been discussed with great circumspection in Ontario — a recommendation for compulsory sterilization of mentally retarded people.

Although sterilization laws had been enacted in the United States, beginning in 1907 with Indiana, the question of sterilizing mentally retarded people seems not to have been discussed in Ontario until the 1920's. Even the Hodgins report makes no mention at all of sterilization. By 1931, however, sterilization laws had been enacted in twenty-seven American states, while Alberta passed the first Canadian sterilization act in 1928, with British Columbia following in 1933. By January 1, 1933, 16,066 people, 6,999 men and 9,067 women had been sterilized in the U.S., although of this total, 53 percent or 8,504 had been sterilized in the state of California alone. In the nine years from 1928 to 1937, 516 people, 181 men and 335 women had been sterilized in Alberta, and by 1962, more than 2,000.[5]

Sterilization had first been put forward as a method for cutting down on the numbers of mentally retarded people, thereby alleviating the social problems they presumably caused. On January 18, 1926 an influential

letter appeared in the *Times* from ten physicians advocating sterilization as "the only effective means of preventing propagation." The difficulty with this argument was that it was based on certain questionable assumptions about the hereditary nature of mental retardation as well as on equally questionable assumptions about the fertility of mentally retarded women.

Thus, during the 1920's and 1930's a debate raged over the scientific basis of the case for sterilization, with distinguished scientists arguing on both sides of the matter. Helen MacMurchy entered the debate in 1934 with a book entitled *Sterilization? Birth Control?*[6]. Dedicated to "The Canadian Mother" the books consists of two long essays, one on sterilization, the other on birth control. Drawing extensively from speeches, letters or secondary sources, MacMurchy presents both sides of the matter, although she concludes that non-compulsory sterilization should be permitted in the case of feeble-minded people about to be released from institutions. In this she was joined by the Eugenics Society of Canada whose president had argued in 1933 that, "there can be no doubt that the feeble-minded are increasing out of all proportion to the rest of the population."[7] Accordingly she advocated a program of voluntary sterilization for the feeble-minded about to be discharged from institutions. The Ontario Medical Association meeting in Hamilton in 1933 also endorsed a resolution supporting the voluntary sterilization of "inmates of institutions who are about to be discharged." Among the reasons was the fact that "mentally defective persons are increasing out of proportion to the rest of the population."

On February 4, 1935 Premier Mitchell Hepburn received a delegation from the Eugenics Society of Canada to discuss the question of sterilization. Strangely, in the Premier's file on sterilization at the Ontario Archives, is a one-page sheet containing selections from J.H. Landman of the Society entitled "Human Sterilization." The selections point out that sterilization would not be effective in reducing the numbers of mentally retarded people. Although the paper has the words "Eugenics Society of Canada" scrawled at the top, it is difficult to know why an argument so contrary to the Society's position would have been sent to the Premier just at the time of their meeting. However, there is no evidence as to whether or not the Premier read this or any of the other documents in the file.[8]

But there were those who dissented from the view that mentally retarded people should be sterilized. In his encyclical on marriage of December 31, 1930, Pope Pius XI had condemned sterilization in the following terms:

> There are some who, over-solicitous for the cause of eugenics...wish to legislate to deprive these [people] of that natural faculty by medical action despite their unwillingness; and this they do not propose as an infliction of grave punishment under the au-

> thority of the state for a crime committed, not to prevent future crimes by guilty persons, but against every right and good they wish the civil authority to arrogate to itself a power over a faculty which they never had and can never legitimately possess.... Public magistrates have no direct power over the bodies of their subjects. Therefore, where no crime has taken place, and there is no cause present for grave punishment, they can never directly harm, or tamper with the integrity of the body, either for the reasons of eugenics or for any other reason...[9]

The reasons given by the Pope are worth pondering, for aside from the Catholic Church, and isolated exceptions such as Josiah Wedgwood, the English Radical MP who fought so courageously against the 1913 English Mental Deficiency Act, very few voices were raised to protest against the moral implications inherent in mental retardation policy.

However, there were scientific objections to sterilization proposals. The most important came in a letter to the *Times* on January 20, 1926, from three members of the Central Association for Mental Welfare, including the eminent British authority on mental retardation, A.F. Tredgold. The signatories argued that sterilization would have "very little effect in the prevention of mental deficiency, it would certainly lead to serious social evils and it would be inimical to defectives and to the community were it to be adopted." The "social evils" referred to were promiscuity and venereal disease. Certainly it was presumptuous of those who opposed sterilization to do so in the name of a sexual morality which not everyone shared, and to condemn in advance behaviour, which even if it had resulted from sterilization, would have been harmless in itself, albeit in violation of their own middle class conventions. But the question of venereal disease resulting from sterilization is a bit more complicated.

It is difficult to know the degree to which fear of having children actedas a restraint on sexual intercourse during 1920's, at a time when artificial birth control was not widely practiced.[10] But the recent recrudescence of venereal disease consequent with the adoption of the birth control pill and other devices lends some credence to the argument that venereal disease and birth control devices are related. In any case, those who supported sterilization measures certainly took these arguments seriously and tried to counter them. In an editorial in the *Canadian Public Health Journal* in February 1931, Dr. C.B. Farrar, superintendent of the Toronto Psychiatric Hospital, mentioned Tredgold by name in arguing that the statistics from California showed that whereas among mentally retarded women, 75 percent had been sex offenders prior to commitment, only 8 percent were "sexually delinquent" after sterilization and parole. Thus, Farrar contended, promiscuity decreased and with it the opportunities of contracting or spreading venereal disease.[11]

Perhaps the most reasoned discussion about sterilization appeared in the Report of the Departmental Committee on Sterilization, appointed by

the British Ministry of Health, and known as the Brock Report of 1932. Committee consisted of a number of members of the Eugenics Society, including R.A. Fisher the statistician, and A.F. Tredgold. The report was quite moderate, and in some ways, damaging to the custodial-sterilization argument. For example, the Committee noted that after intensive study there was no evidence to support the contention that mentally retarded people produced more children than other people. "Except for a relatively small number of isolated instances, we find that there is no evidence of excessive fertility and indeed it would be easy to set off against these exceptional cases a much larger number of cases in which the fertility rate was low. The supposed abnormal fertility of defectives is, in our view, largely mythical and results from the accident that from time to time distressing exceptions to the general rule find their way into the Courts and are noticed in the Press."[12] The Committee also struck a blow at another major assumption of the custodial school in observing that "it is impossible in the present state of our knowledge about the causation of mental defect to forecast with certainty whether a child of any given union will exhibit mental abnormalities."[13] The Committee noted that there was a consensus among experts that the proportion of mentally retarded people with obviously retarded parents was quite small.[14] On the basis of these arguments, therefore, the Committee was quite skeptical about the usefulness of sterilization as a means of reducing the numbers of mentally retarded people.

Of course, the Brock Report did not appear until 1932 while the Ontario Royal Commission on Public Welfare reported two years earlier, but none of the ideas contained in the Brock Report were particularly new, indeed evidence for them had been mounting for the past two decades. The Ross Commission, however, repeated almost literally the discredited arguments of the custodial school. They supported the view that mental retardation was mainly inherited, a view that Dr. Hincks had already questioned in his 1925 speech to the Social Service Council. Moreover, according to the Ross Commission: "Elaborate statistics in the case of Ontario, as of all civilized communities, indicate that a great part of crime and prostitution is due to heredity or to mental deficiency.... Inevitably a question arises why an immoral defective or an immoral criminal should be free to propagate more defectives or more criminals.... Your Commission recommends that some endeavour be made by legislation to lessen the amount of evil which is certainly promoted by unchecked sexual freedom of criminals or defectives who have a record of immorality." The Commission also reported that "from 60 to 75 percent of all defective children are the offspring of defective parents on one side or the other," a statistic which Hincks had already controverted in his speech of 1928 before the Social Service Council of Canada.[15] And the Commission recommended that known, "immoral" defectives about to be released from provincial institutions be sterilized. In support of this proposal the Commission adduced the 6,000 sterilization operations re-

ported to have already taken place in California, and the Alberta legislation which provided for sterilization in similar circumstances.

On the question of special education and institutionalization, the Commission took an equally hard line, indeed their recommendations went far beyond what Hodgins had suggested in 1919. On the possibility of training mentally retarded people, they were extremely negative, stating that "mental defectiveness cannot be cured. It is a lack at birth or caused early in life by disease. The victim, however, can be trained, sometimes, and somewhat, to be a self-supporting member of society.... The defectives propagate defectiveness terribly." The Commission also managed to twist the words of Dr. H.E. Amoss, the Inspector of Auxiliary Education in 1928. Amoss had pointed out that not more than 1,500 Ontario school children were below 50 percent mentality and not more than 12,000 between 50 and 75 percent. "At least 10,000 of these dull and backward children can be trained to become fairly efficient citizens without being stigmatized or institutionalized in any way."[16] But the Royal Commission on Public Welfare reported Amoss as saying that "there are more than 10,000 very backward children in the Province, of whom the majority are of an irresponsible grade of mentality. From such defectiveness comes a large proportion of the immorality and crime in the community." No wonder then that the Commissioners rejected the idea of community living. "A suggestion has been made that some system of placing mild types of mental disease in private homes might be established. We do not think that any plan of distributing demented persons among the community or into life would be found to have compensating advantages." The Commission also endorsed the idea of identifying and registering mentally retarded children in the school system. Every school principal in Ontario would be compelled to report the name of every child in the school "who seems to be mentally backward." These names would then be registered with a special government officer who would have the children examined by a psychiatrist and a psychologist. At the same time, travelling clinics, attached to mental hospitals would assist in the identification and registration of children under school age as well as of adults. "Children with IQs of less than 50 would be placed in institutions. A child of 50 IQ or less is practically hopeless. The unfortunate child is of the imbecile or idiot class...all such children of poor parents of less than 50 IQ need to be placed in an institution and must live all their lives in it. From 50 IQ upwards, children can be trained more or less. Those of 70 or 80 IQ can be trained to earn a decent living."[17]

One of their major recommendations was that 200 beds be added to Orillia at a total cost of $830,000, that two vocational schools for "backward children" (apparently those of above 50 IQ), be established to accommodate 1,000 to 1,200 children, and that a 150-bed industrial refuge for females be built at a cost of $577,500. Possibly the only anodyne recommendation was that the establishment of auxiliary classes be made compulsory. But even here the motive was to relieve the regular classes

of the burden of mentally retarded children, and to facilitate their identification and registration.

As regards public welfare as a whole, the Commission noted that it was impossible for the provincial Inspector of Hospitals, Charitable and Corrective Institutions, along with two assistants, to properly inspect over 400 provincial institutions and private hospitals. Thus, it recommended the establishment of a Department of Public Welfare under a Cabinet Minister, with a Deputy Minister and a series of Directors heading different branches, including a Director of Mental Hygiene responsible for supervising the mental hospitals, mental retardation hospitals and the preventive clinics.[18]

Although the Ferguson government did not follow the Public Welfare Commission's recommendations regarding sterilization, the compulsory institutionalization of mentally retarded people, or the establishment of additional institutions, it did accede to some of the administrative proposals. For example, on September 16, 1930 the government created a Department of Public Welfare which then took under its wing the Mother's Allowance Commission, the Old Age Pension Commission, the Soldier's Aid Commission, the Children's Aid Branch, Industrial Schools, Houses of Refuge and Orphanages. The government also instituted a mental health program and organized mental health clinics at the various provincial hospitals and asylums. It authorized the construction of two 150-bed cottages at Orillia, one for boys, the other for girls, in order to reduce overcrowding, but it ignored the suggestions that two vocational schools or a training hospital be established.

The work of the Ontario Royal Commission provides an interesting contrast to the 1927 report of the Nova Scotia Royal Commission Concerning Mentally Deficient Persons. The Nova Scotia Commission had asked Dr. Hincks to conduct a survey of mentally defective people in the province and to make recommendations for care. But the Nova Scotia Commission arrived at a much more moderate set of conclusions than the Ontario Commission of 1930. It rejected the idea of sterilization because "too little is known regarding the hereditary nature of feeblemindedness and the total results and effects of sterilization." It also rejected the idea of lifelong custodial care for the majority of mentally retarded persons, observing that many of them "under favourable conditions" could become valuable citizens. And the Commissioners referred to work in Massachusetts which proved that it "is neither in the interest of many of the feeble-minded nor of the State to segregate them wholly for life." The Commission concluded with a recommendation for a training program in special schools, the object of which would be to return as many people as possible to the general community.[19] Yet even the Nova Scotia Commission could see no other alternative than permanent institutionalization for the "very low grade and those who cannot be trained to adjust themselves to their environment." In contrast to both Ontario and Nova Scotia, Alberta had passed its Act Respecting Mentally Defec-

tive Persons in April 1919. It was the most draconian measure of its kind in Canada since it provided for the compulsory institutionalization of mentally retarded people, even against the consent of parents or guardians.[20] Nine years later, on March 21, 1928, the Sexual Sterilization Act was passed establishing a four man Eugenics Board which could authorize the sterilization of mentally retarded people where there was a "danger of the transmission of the defect." In the 1928 version the consent of a parent or guardian or an order of the Ministry of Health was necessary for sterilization, but in an April 14, 1937 amendment, consent was eliminated in the case of mental defectives.

Special Classes in the Interwar Period

The Ferguson government followed the example of its predecessors by increasing accommodation at Orillia, enacting some of the less costly suggestions of the social reformers by establishing mental health clinics at provincial asylums, but dragging its feet on the question of establishing additional custodial institutions, as well as a province wide system of identification and registration of the feeble-minded. In the field of special education, however, the pace of change was exceedingly rapid. In 1920 Helen MacMurchy had resigned as Inspector of Auxiliary Classes and had been replaced by Dr. S.B. Sinclair, an educator who had made his way up the educational system from high school teacher, elementary school principal, principal of the Hamilton Teacher Training School, to Dean of the Teacher's School at MacDonald College, Quebec.

Under Sinclair auxiliary vocational classes for adolescent mentally retarded pupils were established, IQ tests rather than medical examinations were used to identify mentally retarded children and, most important, Sinclair tried to convey to the public a positive rather than a negative attitude toward mentally retarded children in auxiliary classes. In justifying the use of IQ tests rather than the general physical examination MacMurchy had favoured, Sinclair noted: "If I take one of these children, and compel him to run the gauntlet of half a dozen specialist examinations, label him with some opprobrious name, exaggerate his imperfection, and advertise him on the housetops as a menace to society, I not only unjustly stigmatize him for life and cause untold suffering to himself and his friends, but I also render all subsequent treatment doubly difficult."[21] For Sinclair, then, a low key approach to education for mentally retarded people was the best means of ensuring the success of auxiliary classes. In 1925 he reported that "there is growing sentiment in favour of using the term backward instead of such terms as feeble-minded when referring to such pupils."[22] In his 1927 report he observed that if backward children were placed in classes by themselves, with sympathetic and kind teachers, and if the class was treated as "an ordinary school class, there is no stigma and no opposition by parents."[23]

Throughout the years that followed, Sinclair and his successor H.E. Amoss continued to protest against using pejorative labels such as feeble-

minded, sub-normal, "or any other term which might in any way mark the pupil as a person distinct from other children."[24] This approach brought Sinclair into conflict with the CNCMH for in 1925 he wrote to Professor E.D. MacPhee complaining: "Perhaps I ought to say to you that the use of the terms 'feeble-minded,' 'sub-normal,' 'defective,' 'dub,' and 'weak-minded' as applied recently at public meetings and in the public press when reference is made to auxiliary classes is being deeply resented by parents and if the habit is continued it is likely to render the continuance of Auxiliary Classes impossible."[25] In 1927 Sinclair appears to have prevented MacPhee from administering a questionnaire to auxiliary class teachers arguing that his own policy had been to "call only the minimum of public notice to the abnormality phase of the work and in stressing the normal as far as possible" and he opposed those who preferred a "publicity campaign." There is also some evidence that on one occasion when the CNCMH was allowed to do a survey of mentally retarded children in one Ontario city, the names of the children were made public, much to Sinclair's disgust.[26] But Sinclair's opposition to stigmatization was limited to the children in the auxiliary classes. In 1928, he noted that all the children in the auxiliary classes had IQs of 50 and above. "The man on the street has always held that such terms [as 'feeble-minded' or 'mental defective'] would be applied only to people who are less than half-witted [below 50 IQ] and prior to the discovery of intelligence tests the terms mental defective and feeble-minded were not applied in Ontario to people of over 50 percent mentality."[27] In fact, this was not true, for social reformers and government authorities alike had used these terms to apply generally to the entire class of mentally retarded people, but Sinclair wanted to limit the use of pejorative terms to mentally retarded children of under 50 IQ and ineligible for the auxiliary class system. In 1928, Sinclair noted a "pleasing feature of the year," the announcement by Dr. Goddard, "the eminent authority on feeble-mindedness," that in his opinion no child above 50 percent mentality should be called mentally defective.[28]

But one implication of drawing the line between those who should be labelled feeble-minded and those who should not, was to suggest that those below 50 IQ were candidates for institutionalization. This implication actually found its way into policy, for in a confidential survey of "abnormal children" conducted in the Ontario public school system in 1926, the first sentence reads: "The following report is only for children who should be placed in special classes or in institutions...."[29] The form warned that "subnormal" children were above the average class age, but that over-age children who were retarded because of a late start, change of school, distance or language should not be considered subnormal. The form noted that children from "50 to 75 percent mentality should be considered special class cases and those below 50 percent institutional cases." Sinclair reported that the survey showed 8,213 children needed special classes and 1,036 need institutionalization. Of those who needed

institutionalization, 454 came from rural areas and 582 from urban areas. It is impossible to determine what the actual effect of this survey was on those children who were described as suitable for institutions, but the echoes of the old distinction between the curable and the incurable insane, or between the harmless and the anti-social retarded continued to be heard.

Whatever the fate of those children, the number of classes for mentally retarded children with IQs of 50 and above continued to increase. Whereas in 1920, the year of Sinclair's appointment, there were 17, by 1928, the year of his retirement, the number had increased to 150. By 1930 there were over 2,000 pupils enrolled in these "Training Classes" and by 1939 just under 3,000.

B.T. McGhie and Deinstitutionalization

The most interesting development in the area of mental retardation policy during this period occurred at Orillia following the sudden death of superintendent J.P. Downey in 1926. His tenure at Orillia had given rise to criticism because of his preoccupation with reducing expenses by putting every able-bodied patient to work, and largely ignoring the rest. There was even a report that when Dr. Hincks of the CNCMH and his assistant Marjorie Keyes visited Orillia in the 1920's they saw a room full of commode chairs with helpless patients tied to them for the entire day. And Miss Marion Harvie, a teacher at Orillia from 1922 to 1926, noted that during her time at Orillia she never saw the inside of buildings other than those housing the trainable retarded.[30]

Given Downey's commitment to economizing on asylum expenditures it is somewhat surprising he never considered the kind of parole or community release system that was then being used in places like Massachusetts. But perhaps his adherence to the custodial model of care, and the fact that as a non-physician he did not engage in the kind of international exchange of ideas that was characteristic of the field during this time, may explain this. Downey was followed by Dr. W.C. Herriman as acting superintendent. In 1928, Premier Ferguson decided to appoint Dr. B.T. McGhie as superintendent of Orillia.

McGhie had been in charge of Westminster Hospital, a federal mental hospital in London, Ontario, from 1920 to 1927 and had been associate professor of mental hygiene at the University of Western Ontario. Of all the superintendents, McGhie turned out to be the most dynamic and the most imaginative. Upon his appointment, he immediately hired three psychologists from the University of Toronto, C.R. Myers, G.P. Cosgrave and E.D. MacPhee (the latter, a member of the CNCMH), and charged them with the task of administering intelligence tests to the patients at Orillia, assessing their capabilities and elaborating a new training program. McGhie also organized a system whereby student nurses took part of their training at Orillia and he encouraged the medical and educational staff at Orillia to visit institutions in the U.S. and Canada for

further training. In February 1929 McGhie and E.D. MacPhee jointly published a 61 page monograph which gives an interesting and in many ways remarkable insight into McGhie's ideas on mental retardation. It should be emphasized that McGhie's views on deinstitutionalization and community integration for mentally retarded people were expressed at a time when many people, including some of the major figures in the field still held to some version of the menace of the feeble-minded idea.

In a chapter entitled "Point of View," McGhie and MacPhee express an inclusive rather than an exclusive view of mentally retarded children. They are seen as differing "only in degree and not in kind from the normal and superior: the points of resemblance of the groups are much greater than the differences." On this basis, the authors argue that mentally retarded children should be as eligible for inclusion within the existing social service system as a normal child.

> The social implication...is [that] a similar provision should be made by society for the training of these children, except insofar as the subnormal intelligence or physical handicap themselves limit such training. Society today considers that it should ensure to children adequate formation in fundamental habits such as eating and sleeping, dressing and undressing, elimination, etc., a minimum of formal education and vocational preparation sufficient to enable the person to achieve, up to the limits of his ability, economic independence; protection from mental and physical injury and the formation of healthy social attitudes, habits and standards.... These things society accepts as its obligation to all children and it sanctions or creates institutions by which these aims are to be achieved. The home, the school, the church, the playground and industry are the institutions charged with this responsibility and to each of them society allots some part of its obligation. When for any reason one or the other of these institutions is unable to perform its duty, society creates a new institution to which it entrusts this task. When the training required is much too complex or much too tedious, or much too specialized for the regular agencies to deal with, or when one of the institutions is absent altogether as in the case of illegitimacy, or when the general social environment is itself a menace to the mental or physical health of the child, then an institution must be created with special equipment and special staff to carry out these functions. Such an institution is the Ontario Hospital at Orillia, created by society for the training of those children who require more assistance from society than the ordinary agencies provide.[31]

What McGhie and MacPhee are doing here is building a case for increased societal responsibility for the welfare of mentally retarded children. They do this by arguing against the notion that there is a distinct difference between normal and mentally retarded children, and then

suggesting that just as society assumes certain educational and welfare responsibilities in the case of normal children, it should do the same for mentally retarded children. Moreover, the authors were trying to suggest that the main function of Orillia was to provide specialized services as a part of a spectrum of social services in the community, not to institutionalize retarded people for life. If Orillia differed from other social service agencies, it was not because it had a uniquely different, custodial role to play, but rather because it was called upon to perform a multiplicity of functions which no one community social service agency could yet fulfill. "Only when one keeps in mind the wide range of institutions for which the hospital must substitute can one appreciate the variety and complexity of the task with which this institution is charged. For many persons it must perform all those social obligations usually assumed by the home, school, church, etc...it must, as does every other home, prepare the child to leave the institution."

In this historical context, the notion in Ontario that the main purpose of Orillia was to prepare mentally retarded children to return to the community was radically new. Once again, it should be emphasized that the Royal Commission on Public Welfare of 1930 argued that most mentally retarded people were fit only for permanent institutionalization. And yet, in 1929, here was the superintendent of Orillia arguing a completely contrary view. Nor did McGhie and MacPhee shrink from the consequences of their views.

> This task of deinstitutionalization is much more difficult than that undertaken by the average home, and that for two reasons — it involves a more radical change in the mode of life of the person, and it requires the provision of community agencies for assisting and supervising the person during this period of adjustment. Both the normal and the subnormal must become vocationally competent, but the subnormal must be even more efficiently trained than the normal child, since he has less initiative in meeting altered conditions....the point of view of the Staff of this Hospital is to assume that every patient should some day be re-established. We realize that such a goal cannot be achieved, but with this as our aim the common assumption that commitment to this Institution means permanent segregation is done away with, and it then becomes a problem for the Staff of this Institution to discover why each individual patient is continuing in the hospital. As far as possible we try to envisage our patients as normal children; as far as possible we intend that the environment in which they live shall be that of the normal child.[32]

These words could easily be used to describe the deinstitutionalization philosophy of the 1970's and 1980's, or to define current thinking about the role of large mental retardation institutions. It is incredible when one realizes they were written in 1929. McGhie is indeed a unique figure in

the history of mental retardation policy in Ontario, not only because his attempts to establish a community training program, to initiate a program of boarding-out and probation, and to re-orient policy away from a custodial and toward a community living model presaged the later reforms of the 1970's and 1980's, but also because his ideas on mental retardation policy were completely in opposition to the conventional wisdom of the previous three decades.

In a speech given to the Canadian Public Health Association on May 20, 1930, written shortly before he was appointed Director of Hospitals and Sanitoria in the Department of Health, McGhie argued that the most economically feasible way of dealing with the mentally retarded would be to treat them in the community. "The social problem, or, in other words the problem of the community, would seem to be to provide for the necessary training and socializing of the retarded individual [note the use of the term "retarded" here] and, having made this provision (through home and parents, social agencies, institutions, etc.) to educate the so-called 'normal' members of the social group to adopt a helpful and understanding attitude which will enable the retarded members to take their place in society and be reasonably happy." Moreover, McGhie pointed out that a statistical study at Orillia showed that 24.5 percent of cases of mental retardation at Orillia had been caused by birth injury, endocrine disturbance, malnutrition, epilepsy or other pathological conditions. From this he argued that if whooping cough, scarlet fever, measles, etc., could be prevented then a large proportion of the causes of mental retardation might be eliminated.[33]

Six years later, on December 22, 1936 McGhie again spoke before the Canadian Public Health Association on "The Problem of the Subnormal in the Community." In elaborating on what has since become the prevailing view on the nature and treatment of mental retardation, he pointed out that it was incorrect to assume that mental retardation was inherited from one's parents. Rather, he said, statistical studies showed that mentally retarded parents appeared to be a "significant factor in less than half — probably not more than one-third" of the cases of mental deficiency studied. McGhie also noted that although it was estimated that there were about 60,000 to 70,000 mentally retarded people in the province, only about 2,000 were institutionalized while only 5,000 had even been identified by 1937. This indicated that the vast majority of mentally retarded people were able to function in the community without ever coming to the attention of social agencies or having to be institutionalized. McGhie condemned the argument that mentally retarded women had more children than normal women. Referring to a study of the Committee of the American Neurological Association for the Investigation of Eugenical Sterilization, he said: "Families in which mental defectives occur are *not* larger than the average for the general population...mental defectives have much *less* than the average number of children...for mental defectives the birth rate is lower and the death rate higher than for the general

population [his italics]. There is no valid evidence for supposing that mental deficiency is increasing in frequency and there are no grounds for sensational alarm concerning the salvation of the race in respect to the subnormal." Then, on the question of policy, McGhie attacked the proposals put forward over the previous decades by the social reformers from the PACFM, the CNCMH and the other pressure groups of the time. On registration of mentally retarded people he observed that it would probably be impossible to identify all the mentally retarded people in the province, nor would it be necessary to do so since a majority needed neither help nor treatment. On institutionalization McGhie pointed out that it would be economically impossible to fund a policy to identify and remove the mentally retarded from the community and to provide sufficient institutions to house them. On sterilization, the issue which had replaced the menace of feeble-minded women as the burning question of the 1930's, McGhie argued that not only had the assumed benefits of sterilization been drastically overstated, but that it would not even achieve the minimum objective of decreasing the number of mentally retarded people. "Unfortunately, eugenic sterilization has sometimes been proposed in connection not only with mental defect but also with mental disease, criminality, immorality and a variety of other conditions which are often lumped together indiscriminately." Yet, McGhie pointed out, it was untrue that the number of mentally retarded people was increasing. Thus the dramatic possibility of being swamped by mentally retarded people unless sterilization policies were immediately followed was an illusion. In addition, sterilization would have no effect on the actual numbers of mentally retarded people in a population since the majority of mentally retarded people were born to normal parents. "Frankly, I see no reason to fear that, without sterilization mental defectives will swamp the population, nor do I see any reason to hope that, with sterilization, the problem of the subnormal will be resolved."[34] S.J.W. Horne, McGhie's successor at Orillia, put the matter succinctly when he replied to a medical officer of health who had advocated sterilization. Referring to the difficulties Canada was then having with the various railways fighting over lines and traffic, Horne said: "The feeble-minded certainly didn't cause the railway problem."[35] Given the fact that sterilization laws had already been enacted in more than half the United States, in Alberta and British Columbia, it is probably thanks to McGhie that no sterilization legislation was enacted in Ontario.

McGhie also criticized the tendency of so many social workers to "assume that, having determined the presence of mental defect in a delinquent, they have explained the delinquency. But delinquency occurs in a mental defective for precisely the same reasons that it occurs in a normal person. It does not follow that the mental defective should go to an institution. It does follow that whatever social treatment is indicated in the one case is also indicated in the other." For McGhie, then, the only answer to the question was special education and community supervi-

sion. But by special education McGhie did not mean merely auxiliary classes, but a system whereby mentally retarded people could be given "social education" through parents, social agencies and schools. "In conclusion, the problem of the sub-normal appears to be essentially a community problem — one which must be faced and dealt with by the community."[36]

Certainly, McGhie's ideas on mental retardation policy were influenced by developments in the northeastern United States, and particularly by the ideas of Walter Fernald of the Waverley, Massachusetts school, George A. Wallace of the Wrentham State School, and by the changing ideas of Dr. Charles Bernstein of the Rome State School.

Although most American authorities had argued very strongly for the custodial case prior to World War I, Walter Fernald began to suggest that mentally retarded people might well survive outside the institution if given the proper kind of help and support. Fernald's dramatic change of opinion on custodialism was first made known to the public in his famous "After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-Five Years." In a study of 646 patients discharged during that period, Fernald discovered that many of the men held good, regular jobs, that only 32 of 470 still alive at the time of the study had been jailed, and that of the 176 women discharged, 27 were married and had amongst them 33 children. The social workers investigating these cases could not definitely identify a single case of mental retardation among these children.

So surprised was Fernald by these results that he hesitated for two years before publishing them.[37] Fernald's study was published at a time when various authorities began to argue that it was both unrealistic and unnecessary to expect the government to provide custodial care for all the mentally retarded people in the community, and that some system of parole and community care was a viable alternative to institutionalization. Institution superintendents now began to experiment with various kinds of home-care, after-care, half-way houses, and boarding homes in an attempt to integrate mentally retarded people in the community. In 1922, a Michigan psychologist noted: "We realized that a very large number of...mental deficients were living harmless lives in the homes or in the community and we asked ourselves why many of those who are housed in our institutions for the feeble-minded could not also live outside and be at least partially self-supporting." And in a survey for that year, she noted that 17 institutions in the United States had some kind of parole system, which among them had paroled 1,415 mentally retarded people.[38]

Doubtless B.T. McGhie kept up with developments in the U.S. through the professional literature, and especially the *Journal of Psycho-Asthenics* where the major articles in the field were published, and where Canadians such as Helen MacMurchy and others had provided information on policy in Canada. Moreover, according to Professor C.R. Myers

who worked with him at Orillia, McGhie had visited the Judge Baker Child Guidance Clinic in Boston along with Clarence Hincks of the CNCMH and had met there with Walter Fernald.[39]

Unfortunately, McGhie's tenure at Orillia was extremely brief, for on November 1, 1930 he was appointed Director of Hospital Services. In that year, hospitals were transferred from the jurisdiction of the Provincial Secretary to the newly-organized Department of Health and in 1931 McGhie became Deputy Minister of Health.

While at Orillia McGhie implemented a probation program. His first report as superintendent in 1928 notes that the school program had been changed "in order to bring knowledge more closely into contact with life and make it socially effective. Judged by the fact that 28 pupils who were placed on probation from the school during the year are satisfactorily adjusted in the community and earning their own living, the new school plan is likely to be a success."[40] After McGhie's departure in 1930, the senior physician, S.J.W. Horne was appointed superintendent. His reports indicate he tried to follow the policies first sketched by McGhie. The staff continued to administer psychometric examinations to the patients and research continued on idiots and on patients suffering from congenital syphilis. Horne also placed 10 boys on farms in the community, while in 1931, Colony House, a residence for mildly retarded women was established in Orillia.

Conceived by B.T. McGhie and Katherine Day, the Chief Social Worker at Orillia, the residence was opened by S.J.W. Horne on July 20. According to Horne, the number of girls in residence averaged around 12 to 15. They were placed at homes in the vicinity to do housework, starting work at eight in the morning and returning to Colony House at around six. The wages were paid directly to Orillia with half going to the girl's account and half to the institution. A girl who lived at the home where she worked was placed on six months probation, which could be renewed. During that time she was supervised at "irregular intervals.... If a girl has shown a complete social readjustment over a lengthy period of time the hospital might discharge her, but this is not our policy at present. We believe that the public interest is best served by allowing her economic independence under careful supervision."[41] But the experiment was short-lived for in June 1932, local women complained to the Mayor of Orillia that the girls of Colony House were taking jobs away from them. In December 1932, Colony House was destroyed by fire.

One year later, Marion E. Haugh, a Social Service Internee at Orillia did a survey of the girls' probation scheme at Orillia, basing her findings on the case records of 53 girls who had gone out on probation from Orillia from 1929 to 1933. Haugh pointed out that the idea behind Colony House was to help girls make the transition from institutional life to life in the community. Colony House provided them with an opportunity to live with a small number of people in an atmosphere more resembling a room-

ing house than an immense institution. Moreover the presence of the matron helped to "instill a desire for personal neatness and to introduce her to certain social amenities." Colony House also served as a permanent home for those girls who could not board with their employers. According to Haugh "at present the attempt to re-establish girls in the community is confined to one occupation" (housework) although it was hoped that sometime in the future the probation scheme might "be extended to include girls operating power machines and working in factories where a high degree of skill is not required." In her study Haugh also found that the average IQ of the girls was 65, with the lowest IQ 43. She also observed that the girls came to Orillia "in its capacity of hostel or in that of corrective training school." In other words, some of the girls she studied came to Orillia because they had no other place to go, Orillia still fulfilling its ancient function of asylum, while others came because they had run into trouble with the law, so that Orillia also functioned as a means of social control. She counted fifteen girls among the first group: three orphans, four illegitimate children and eight whose homes had been judged as unfit environments. All of these had been sent by Children's Aid Society. The second group was composed of thirty-eight girls who had been admitted by warrant or by the recommendation of juvenile court. Sixteen among these were unmarried mothers, eleven having one child, four with two children and one having seven illegitimate children. Eight had been admitted "for abnormal sexual tendencies, three charged with promiscuity, four with moral weakness and one with nymphomaniacy. Two girls were committed for petty thieving and fourteen were transfers from industrial schools and the CAS where they were extreme behaviour problems." Contrary to common belief Haugh found that a long period spent in institutions did not make it difficult for a person to adjust to the community. In five cases where the girls had spent between fourteen and twenty-seven years in the institution all were successful in remaining on probation. She also noted that the policy at Orillia was to divide entering patients into those whose IQs were above and those whose IQs were below 50. The latter were given some task to perform in the institution, while those with IQs above 50 were placed in a "training programme expressly designed to make girls competent to serve as domestics in the community." Finally, Haugh found that there seemed to be little relationship between success at Colony House and IQ. After the 1932 fire, Orillia continued to send girls on probation to the Haven in Toronto, originally established in 1867 as a half-way house for women discharged from prison but given over to mentally retarded girls from Orillia and Cobourg after 1925.[42] In 1965 the Metropolitan Toronto Association for Retarded Children took over the operation of the Haven, now known as Lorimer Lodge.[43]

In 1931, the first year of Horne's tenure as superintendent, 47 people were placed on probation, the same number as the previous year. In 1933, 131 residents were placed on probation. From 1933 until the 1940's the number of patients either discharged or placed on probation

hovered at around 8 percent of the total population, more than at any time in Orillia's history. One program that began in 1931 probated "high grade boys" to local farmers.[44] Ironically, one effect of the probation program was to drain Orillia of its most able patients. Since the age and intelligence level of new admissions varied each year, unless an equal number of new patients replaced those trained in the occupational classes, educated in the school or going on probation, then both the educational and probation program suffered. In 1938 Horne complained that it was difficult to keep the occupational school and shops in operation because of the effects of admitting "such a large percentage of low grade patients."[45]

Another technique for returning patients to the community was inaugurated by B.T. McGhie in 1933. This was the boarding-out system patterned after the Scottish scheme whereby mental patients were boarded at nearby homes often owned by staff members from the institution, with the government paying a weekly maintenance fee. In 1939, the scheme was used for the first time for mentally retarded people from Orillia when 13 patients were sent to boarding homes, or, as they were later called "approved homes." In the beginning the government paid $4.50 per week for each indigent patient, but the amount increased over the years. Although the program was an interesting one, it never took more than 150 mentally retarded patients from 1939 to 1951.[46] In succeeding reports Horne continued to complain of how the large percentage of low ability cases were forcing changes in the programs. With the coming of World War II he noticed the same phenomenon as had occurred during World War I, that is, there was an increasing number of requests for the admission of very young children from ages one to five from women whose husbands were in the armed forces. Doubtless many of these women had found jobs and could not care for their children or find daytime help, thus forcing them to seek admission for their children to Orillia.

One irony in provincial policy derived from the establishment of mental health clinics at the Ontario Hospitals in London, Hamilton, Whitby, Brockville and Orillia after 1930. Designed to gather information about the mental health of children in the province, to provide clinical services for the study of retarded children to schools, children's hospitals, social agencies and juvenile courts, one effect of the clinics was to identify and then label additional candidates for institutionalization at Orillia.[47] McGhie, particularly, hoped the clinics would encourage mental hospitals to place patients in the community under the supervision of the clinical groups attached to the mental health clinics. Eventually it was hoped that a comprehensive community service might be established. But since the administration of IQ tests was a routine part of the examinations at these clinics, new statistics on the number of people with mental defect were constantly being produced after 1930. Moreover, so ingrained was the belief in some areas that illegitimacy and mental retardation were associated that in 1941, the directors of the mental health clinics complained that "the number of unmarried mothers being referred for exami-

nation in Ottawa" was extremely large and was taking up a great deal of time. "It was agreed that there was little value in providing the Children's Aid Society with an IQ in these cases and that the belief that such intelligence rating had any significance in respect to the future adjustment of illegitimate children was unwarranted. It was further suggested that an effort be made to discourage the referral of such cases for merely routine psychometric examination."[48] Despite this attitude, a staff member from the Brockville mental health clinic during this time does not recall that there was any particular hostility at the clinics toward, or notice taken of mentally retarded women or of mentally retarded women with illegitimate children.[49]

In 1940, statistics showed that during the previous nine years the provincial mental health clinics had examined 20,903 people and of that number 51 percent fell under the heading of either dull normal, borderline, moron, imbecile or idiot, while 23 percent, or 4,853 fell under the latter three categories. The statistics also show that during that time 1,099 or 5.2 percent were recommended for institutionalization at Orillia, while 3,181 were recommended for institutionalization at other provincial institutions. Although the total number of new patients admitted to Orillia during that time was 2,053, it is impossible to determine what proportion of this number was comprised of those who had been recommended for institutionalization by the various mental health clinics.

Another of McGhie's innovations was the establishment of a "Home Training" program in 1930. This was carried on by social workers or public health nurses attached to the travelling mental health clinics who would visit with families helping them to care for their mentally retarded children or relatives. McGhie gave some illustrations of how this program worked in 1933.

> In one centre, a child with C.A. [Chronological Age] 12-4, M.A. [Mental Age] 4-10, IQ 40, with a speech defect, inability to enunciate words when brought to clinic, started the training course in November, 1930. In September, 1931, the child could write the letters of the alphabet, read from the first eight pages of the primer and make change for two dollars. In December, 1931, he made toy croquet sets and sold them for 50 cents; in January, 1932 he started work, helping to deliver wood for which he is receiving one dollar a week.... Another subject, C.A. 8-4, M.A. 3-2, IQ 22 has been placed on phenobarbital therapy, has learned to clap his hands to music, grasp toys with his hands, throw a large ball, raise himself up beside a chair and take a few steps with the guidance of his mother. The mother states various other exercises are practised to music with fair results.[50]

Despite these success stories, one psychologist who was attached to a travelling mental health clinic during this time recalls that he and his col-

leagues were relatively unsophisticated about advising parents on how to deal with mental retardation.[51] In 1937, however, McGhie reported that parents who were "initially frantic to have their child admitted to Orillia...did not for a moment consider allowing the child to be placed in an institution" at the conclusion of the training program.[52]

These innovations were all intended to relieve Orillia and the other provincial and municipal institutions from the continuing pressure of numbers. McGhie realized that constructing additional facilities was not the answer. "We will never be able to keep pace with this problem in our building programme. Massachusetts, the State of the Union that has done most in the way of building, has a long waiting list for admission at all its training schools...."[53] However, despite McGhie's innovations Orillia remained the centrepiece of Ontario's mental retardation policy until well into the post-World War II period. And S.J.W. Horne soon began to recite the litany which had appeared regularly in every superintendent's reports over the previous seventy-five years. "The ever-increasing demands for admission necessitated the almost continuous rearrangement of Hospital accommodation to provide for the increased admission...it has meant that every day room has been put to use as a dormitory and beds have been placed in corridors."[54] The number of patients at Orillia had increased from 983 in 1920 to 1,411 in 1930 to 1,991 in 1940 and to 2,149 in 1945. By 1946 Horne wrote that accommodation had been stretched to the limit, while the staff shortage which had begun during the war with the departure of almost all the medical and nursing staff, continued so that in 1947 there were three medical doctors, including the superintendent, for a population of 2,269. In that year Horne was unable to hire graduate nurses or even ward aides.[55]

In 1938, the government appointed a Royal Commission on the Operation of the Mental Health Act. The Commission was appointed because of continued complaints to the government about the numbers of people sent by magistrates for observation to the various Ontario Hospitals to determine whether or not the person was certifiable as mentally ill. The Commission discovered that more than 50 percent of those sent for observation were returned to the courts as not certifiable. "It seems to us that the percentage is entirely too high, and indicates that there is not enough trouble taken by the magistrate before sending persons to hospitals under this section."[56] The situation at Cobourg was particularly bad.

The Ontario Hospital at Cobourg had been founded on the site of Victoria University which had sold its property to the government in 1902. At first the government had established a hospital there for aged women, but from 1917 to 1919 it was used as a military hospital. On August 1, 1920, it was opened as an Ontario Hospital. From its inception it had been used exclusively for mentally ill women, although there was always a small proportion of mentally retarded women in the population, in the early years around 8 percent. By the late 1930's, however, with the government under continued pressure from the social reform groups to estab-

lish a separate custodial institution for the feeble-minded, and with Orillia suffering from overcrowding, the proportion of mentally retarded women began to climb. By 1938, the year of the Royal Commission, 295 out of 461 residents, that is 62 percent of the hospital population was comprised of mentally retarded women. By this time Cobourg was supposed to serve as a training school for domestics, many of the women being sent to work in the area, or placed on probation, sent to Lorimer Lodge in Toronto, and then placed at jobs in the Toronto area.

The Commissioners were obviously shocked at the fact that so many of the women at Cobourg had been institutionalized simply because they had become pregnant. "It was our opinion that in some cases had it not been for this sex experience they would not have been found in an institution. Deplorable as this state of affairs can be, it is felt that under the present state of law this is not sufficient justification for locking up a girl and keeping her for an indefinite period in a mental hospital."[57] One remedy the Commission proposed was to establish a Board of Review which would check into the questionable cases at the various Ontario Hospitals, and particularly into those at Cobourg. But another proposed remedy was much more drastic.

"The superintendent of one of the Ontario Hospitals thought that if sterilization was permitted a comparatively large number of young women patients could be liberated and that while they would still be a sex problem in the community they would not be the same problem. We have come to the conclusion that this is true, particularly of the mental defectives who are at present confined in Orillia and Cobourg. A large number of these patients have had pregnancies and this we are convinced has contributed in a large measure to their detention as mental defectives in hospitals."[58]

The Commission recommended that the Medical Act be amended to specifically permit sterilization operations to be performed with the consent of the patient or her parents or guardian. Although the idea of such an act was not particularly radical, the rationale for the suggestion was quite shocking. In effect, the Commission was admitting that large numbers of women had been institutionalized for no other reason than their becoming pregnant and, furthermore, that the remedy was not to ensure that their rights were protected, but rather to impose a further injustice by facilitating sterilization operations. Ironically, this was a form of deinstitutionalization, for the ultimate objective was to return women to the community. But rather than any attempt being made to change community attitudes toward unmarried mothers, the women would be asked to sacrifice their right to have children to community attitudes.

The Commission also observed that one of the reasons for the large population in the Ontario Hospitals was because "in the majority of cases the patients are public charges. In a great many instances the environment in the home is such that probation is impossible, and in another there is a total absence of relations or friends willing to take the responsibility."

The Commissioners noted that the hospital superintendents had submitted a list of 1,015 names of patients who could be cared for in other institutions such as houses of refuge. But there was only limited accommodation available, and given the reluctance of the municipalities to enlarge existing institutions, it was unlikely there would be an increased flow of patients from the provincial to the municipal institutions.

The report of the Royal Commission provides some insight into the state of mental retardation policy in the immediate prewar period. The clamour for accommodation continued with Orillia becoming increasingly overcrowded. At the same time, the Depression had forced major cutbacks in government spending. On July 12, 1934 a letter had been sent to the deputy provincial secretary advising him that all hospital construction had been stopped. This ended the work that had started on a mental retardation hospital at Smiths Falls, and on capital improvements at the various Ontario Hospitals.[59] Total expenditures on all mental health facilities in Ontario declined drastically as a percentage of total government expenditures. Whereas in 1916 almost 17 percent went to the various provincial mental hospitals and to Orillia, by 1930 the figure had declined to nearly 7 percent. In 1942, S.J.W. Horne noted that an increase in admissions had forced him to use day rooms as dormitories and to put beds in corridors. In these circumstances it was impossible for Horne to reduce the numbers. Thus, institutional policy was still constrained by the iron law that the number of admissions plus the number of applications would always exceed the available space. This meant that no matter what educational, probationary or internal economic policies were followed, no matter how much new accommodation was added, nothing could contain the demand for space.

6

Summary — 1900 to 1945

Orillia was always much more than the hospital and training school it claimed to be. Since its inception it had served a number of different purposes so that as time passed the characteristics of the people sent there had changed, and the reasons for their institutionalization varied. In the 1930's Orillia still functioned as an asylum, housing a certain number of senile old, severely retarded, multiply handicapped, or syphilitic people — those who for physical or mental reasons could not survive outside an institution. At the same time, it continued to serve a social welfare function, for there were also present large numbers of children, adolescents and adults who might have survived in the community if there had been some community support systems. Among these were orphans who could not find foster homes, young people who could not find employment, and unmarried women who had become pregnant and had no one to care for them. Above all, as the Royal Commission of 1938 had pointed out, most of the people at Orillia and at the other Ontario Hospitals were poor. From 1934 to 1951, for example, Orillia published figures on the economic condition of the families of people admitted during the year. The categories were extremely crude — "indigent," "marginal," and "comfortable," — with no explanation of the criteria by which people were placed in one or another of these categories, but they give a brief glimpse into the socio-economic background of the families of retarded people admitted to Orillia during this period. For the 17 years from 1934 to 1951 during which statistics were provided between 39 and 57 percent of the families were listed as "indigent" (in 1939 this category was changed to "dependent"), 30 to 53 percent were listed as "marginal," while from 4 to 24 percent came from "comfortable" families. If one

combines the first two categories, never less than 75.7 percent of those admitted to Orillia during these years came from families in straitened circumstances, while during eleven of these seventeen years the combined percentage was never less than 85 percent. Moreover, at least 25 percent of the patients in residence at Orillia during this time were classified as "morons" or "borderline." Considering the fact that the term moron (first used by H.H. Goddard to refer to mentally retarded people with IQs between 50 to 75) must have included people who might have survived outside the institution if only they or their families had been provided with a minimum of help either in the form of financial aid or community or social service assistance, then it is quite evident that large numbers of people at Orillia were there not because of sheer physical or mental obstacles posed by their retardation, but because of the socio-

Table 2. Distribution of First Admissions to Orillia by Economic Condition of Families: 1934-1951

Year	Indigent	%	Marginal	%	Comfortable	%	Unascertained	N
1934	109	47.8	95	41.6	24	10.5		228
1935	19	39.6	24	50.0	5	10.4		48
1936	81	38.9	111	53.3	16	7.6		208
1937	56	40.0	66	47.1	18	12.8		140
1938	84	40.5	93	44.0	30	14.4	18	207
	Dependent							
1939	98	45.7	103	48.0	13	6.0		214
1940	100	52.9	81	42.8	8	4.2		189
1941	86	48.3	85	47.7	3	16.8	4	178
1942	144	56.9	77	30.4	32	12.6		253
1943	101	55.4	48	26.3	33	18.1		182
1944								
1945	72	52.1	45	32.6	18	13.0	3	138
1946	106	52.2	70	34.4	27	13.3		203
1947	112	55.1	74	35.2	24	11.4		210
1948	85	46.9	71	39.2	25	13.8		181
1949	69	43.6	64	40.5	25	15.8		158
1950	132	36.8	166	46.3	60	16.7		358
1951	115	33.9	142	41.8	82	24.1		339

Source: Ontario *Sessional Papers* for various years

economic climate of the time. Finally, Orillia, and, by this time, Cobourg served a social control function, for many of the residents travelled a route that led from the courts, to assessment by psychologists or psychiatrists to institutionalization. Among these people were not only those who had run into trouble with the law, but those such as unmarried mothers who had violated contemporary moral standards.

Thus, despite the efforts of B.T. McGhie or of S.J.W. Horne, it was hardly possible to re-orient mental retardation policy toward some kind of community living solution while community services remained at a rudimentary level. Given the lack of any financial aid for poor parents with mentally retarded children or relatives, the only alternative for the vast majority of people must have been commitment to Orillia or Cobourg.

But why did no one ask the government for help? Why did the parents and relatives of mentally retarded people accept a policy characterized by stigma and based on permanent institutionalization? One explanation can be found by looking again at Georg Simmel's extraordinarily prescient essay, "The Poor." There Simmel discusses the question of what rights the poor have and what society's obligations are towards the poor. His observations are relevant to the case of mentally retarded people. In some societies, Simmel points out, the poor have certain rights to assistance. These rights may stem from tradition, from the fact that since time immemorial the poor have always had a claim on certain forms of public assistance, or these rights may even be embodied in law. According to Simmel the humanitarian is particularly concerned with ensuring that these rights are covered by legislation since requests for aid made on the basis of impersonal law avoid the shame, humiliation, and stigma that usually accompanies a request for charity. In the case of the mentally retarded in Ontario, however, the only "right" that was granted was to apply for a place at an Ontario Hospital. In this case an exchange took place. The individual requesting aid was placed in a public institution and cared for at public expense but he had to sacrifice his personal freedom and suffer the stigma associated with institutionalization. Although some attempts were made to remove the stigma by calling the mental retardation facilities "hospitals" instead of "asylums," and by referring to the "feeble-minded" or the "mentally defective" instead of to "idiots" and "imbeciles," the personal and social costs of depending on state aid were immense.

On this point Simmel differentiates between assistance granted to the poor because they are seen as part of the "social whole," and assistance granted to them as members of a unique category within society. In the first instance the poor are treated as ends in themselves, in the second, as means to other ends or goals. This is particularly relevant to the treatment of mentally retarded people during the period from 1900 to the 1930's, for the effect of the myth of the menace of the feeble-minded (and especially of feeble-minded women) was to increasingly character-

ize a class of people as different from and inferior to the rest of the population. Time and again the feeble-minded were described as comprising a certain percentage of various social problem groups, or, sometimes, as an irreducible social problem group of their own. They came to be perceived as an anti-social and even dangerous minority for whom special policies should be established. Thus policies were justified not in terms of how they would benefit the feeble-minded, but how they would help to solve other social problems by dealing with the feeble-minded as means to these ends. As Simmel put it: "When assistance to the poor derives teleologically from a goal one hopes to pursue...rather than from the causal basis of a real and effective unity among all the members of the group, the rights of the poor dwindle to nothingness."[1] Simmel's point can be starkly illustrated by two quotations from discussions at the annual meetings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons in 1906. According to Walter Fernald: "We have within a year or two noticed the despair that developed when our female patients began to understand that a commitment meant that their prospects of discharge were practically gone, and when we must, in effect, say to recently admitted female patients, 'it makes no difference how well you behave; you may stay here a dozen years; you may lead a perfectly straight and commendable life, but you will never be discharged'."[2] Fernald is saying that mentally retarded women who had never committed any crime nor been sentenced by any court were committed to an institution for life without even the possibility of parole open to the most hardened criminals. In all fairness, Fernald also noted that he had instituted a program of probation and discharge so as to correct the situation. But Fernald was one of the more tolerant of the institution superintendents, and his example was not always followed. Another illustration comes from Dr. Bernstein, superintendent of the New York State Custodial Asylum at Rome, New York.

> I believe firmly that no feeble-minded person should be taught to read and write because I know some of the results of that teaching. I have seen any number of feeble-minded children who, if they had not been taught to read and write, would have been happy in an institution. They are making their parents unhappy when they come to visit them. As I say, if they are to be made custodial cases they must not be made unhappy in an institution.... We are sorry that we ever taught any of them to read and write because they find what they are losing in the world and are constantly hankering after it, and it makes them miserable and their friends miserable, and they often times run away and make the community miserable.[3]

Of course, in addition to recoiling in horror from a perspective which views mentally retarded children purely as instruments to be adapted to institutional ends, one might also ask what these children were doing in

an institution in the first place if they could be taught to read and write.

For Simmel, assistance to the poor was given "so that the poor will not become active and dangerous enemies of society, so as to make their reduced energies more productive and so as to prevent the degeneration of their progeny." These reasons certainly lay behind mental retardation policy from 1900 to 1930, but as the myth of the menace of the feeble-minded began to fade, then these justifications for policy began to vanish as well. Once mentally retarded people ceased to be perceived as a means through which larger social problems could be solved, then mental retardation policy began to recede from the public stage and disappear into the shadows of social policy. Since mentally retarded people no longer posed a threat to society, nothing particularly drastic had to be done, but nothing of any great benefit would be done either. As Simmel points out:

> Assistance is based on the structure of society, whatever it may be; it is in open contradiction to all socialist and communist aspirations which would abolish this social structure. The goal of assistance is precisely to mitigate certain extreme manifestations of social differentiation, so that the social structure may continue to be based on this differentiation. If assistance were to be based on the interests of the poor person, there would, in principle, be no limit whatsoever on the transmission of property in favour of the poor, a transmission that would lead to the equality of all. But since the focus is the social whole — the political, family or other sociologically determined circles — there is no reason to aid the person more than is required by the maintenance of the social status quo.[4]

But Simmel does not answer the question of who or what it is that determines the focus of social policy. Nor is it clear there is a concise answer. In the case of mental retardation policy it is probably much easier to say who or what did not influence policy. Certainly there is little evidence that the electorate was greatly concerned by the issues involved. Despite sporadic press coverage during the years from 1900 to 1920, the public meetings held by the various pressure groups and the deputations that shuttled back and forth between City Hall and Queen's Park, none of the elections during that period were concerned with the issue of mental retardation policy. Nor were the political parties concerned with the issue. If, at one point, the PACFM, and particularly C.K. Clarke seem to have been in contact with N.W. Rowell, the leader of the Liberal Opposition to try to exert pressure on the Hearst Government to implement some of the proposals for establishing a comprehensive policy, there is no evidence that the parties divided along political lines on this issue or that any of the parties thought it worthwhile to use mental retardation policy as a weapon in the political struggle. In a letter to Rowell on April 27, 1916, Clarke wrote: "As I have said publicly on many occasions, the question is not one for party politics...."[5] This is not unusual since many

single interest pressure groups prefer a non-partisan approach for fear that attaching their cause too closely to any one political party will lessen their effectiveness. Nor, if we approach the question from the top down, were the Premier or his Cabinet involved, except intermittently. Of course, the Premiers did meet frequently after 1900 with pressure group delegations and there are some documents showing that Premier Hearst was interested enough to draft some minutes on policy, but there is little to show that it was anything more than a peripheral concern.

But there were two places where policy was actively discussed: among the various concerned pressure groups, particularly the PACFM, and in the bureaucracy, especially in the office of the Provincial Secretary and in the office of Inspector of the Feeble-Minded.

The PACFM and other pressure groups were the main source of ideas and policy suggestions. They were the ones who argued that the primary object of mental retardation policy was to alleviate prostitution, illegitimacy, crime, delinquency, and, after 1918, venereal disease. These early twentieth century pressure groups consisted of a cross section of the Toronto socio-professional élites. Medical doctors were heavily represented in organizations such as the PACFM and its successor the CNCMH, but also present were some of the leading, and wealthier social reformers of the day. Since it had become less fashionable to blame the immorality or bad character of the poor for their problems, new discoveries about the hereditary nature of intelligence and the association between mental defect and social problems allowed these middle class reformers to present an old argument in the guise of "science." Now crime, vagrancy, unemployment, prostitution and illegitimacy could be explained in terms of mental defect. And mental defect had a biological rather than a spiritual source. Thus it was recommended that the mentally retarded not be punished and put into jails with common criminals, but rather sent to refuges, hospitals or other institutions where they could be treated and cared for. But the treatment of mentally retarded people during this time is a classic illustration of blaming the victim, of attributing the source of social problems not to structural defects in society, but to the incapacities or failures of individuals in that society. It is an argument that avoids the question of whether the social or political system is responsible for the creation of social problems. Of course, the social reformers did not uniformly condemn all mentally retarded people to institutionalization for a distinction was drawn between those who could and those who could not benefit by education. In this sense, social reformers simultaneously held both environmentalist and hereditist views. But the penalties of falling into the category of being ineducable and mentally retarded were indeed severe.

The rise of the custodial movement cannot be understood apart from the major socio-economic developments of the time. By the 1880's Ontario was in the throes of industrialization with the accompanying movement of population to the cities, the change in the nature of work from

an agricultural to an industrial economy and the rise of social problems resembling those of Great Britain and the northeastern United States.[6] Throughout the industrialized world, structural upheavals were causing similar problems. And given the general similarities in the class structure and the intellectual climate of these societies, the response to these problems was roughly the same. The Ontario physicians, lawyers, psychiatrists, institution superintendents, and female social reformers who composed the social reform movement of the time exchanged ideas within an international context.[7] Helen MacMurchy not only kept up with developments in mental retardation in the United States and Great Britain through reading professional journals and institution reports, she also attended professional meetings in Great Britain, and the U.S. A.H. Beaton, superintendent of Orillia was a leading member of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons. Thus the findings of Dugdale regarding the Jukes family and of Goddard about the Kallikaks, and the statistics from the English Royal Commission on the Care and Control of the Feeble-Minded were quickly disseminated within Ontario and reflected in policy proposals. And, over time, additional statistics and studies were generated from within Ontario itself.

As regards the relationship between the social reformers and the government, the efforts of the social reformers from 1900 to 1930 were focused primarily on the office of Provincial Secretary. Until 1931 when industrial refuges and other social welfare institutions were transferred to the Department of Public Welfare, the Provincial Secretary had responsibility for all provincial institutions. Since the number of institutions had expanded rapidly, and the scope of social welfare was continually broadening, mental retardation policy soon became just one of a whole series of strands that composed the fabric of social policy. However, while the social reformers continued to pressure for increased provincial responsibility (and expenditures), the inspectors and the government were trying to get the municipalities to play an increasing role in providing social welfare services. Above all, the Provincial Secretary and the government were concerned with the bureaucratic imperatives of efficiency, rationality and economy. While the thrust of the social reformers' demands were expansive, the government's tendency was to be restrictive. While the social reformers were concerned about the danger to the community of the feeble-minded, the government was concerned about underfinanced, overcrowded and understaffed provincial institutions. While the social reformers wanted the government to embark upon a comprehensive program involving the establishment of purpose-built custodial institutions for the adult feeble-minded, the government temporized, expanding existing facilities at Orillia, and gradually converting Cobourg into an institution specifically for the care of mentally retarded women. While the social reformers exhorted the provincial government to spend more money, the government continued to pressure the

municipalities to contribute to social policy. From 1900 on, for example, municipalities were charged ten cents a day for indigent patients sent to a provincial asylum, while in 1912 legislation was passed compelling municipalities to establish houses of refuge.

When compared with the United States, however, the evolution of asylum policy in Ontario gives the impression of remarkable smoothness and continuity. While many of the American state governments were wracked by quarreling about corruption, incompetence or cruelty in the institutions, there were few such scandals in Ontario. And while there are many American examples of friction between state governments and the board of directors of the various asylums, there are no such examples in Ontario. The reason for this contrast is clear. From 1859 an efficient, competent inspectorate had been established. Unlike the U.S., the Ontario asylum system was centralized, and run by the provincial government. There could be no conflict between boards of directors and government simply because there were no boards of directors in Ontario. The mental retardation system was fully bureaucratized from the very beginning.

Most likely it was just because the system was hermetically sealed against outside influences that Hodgins suggested in 1919 that a board of control or a departmental committee be established to register feeble-minded people, to initiate expert studies and to co-ordinate the activities of the various social agencies in the field. Although Hodgins suggested that the board be under the "control" of the Provincial Secretary, it would be chaired by "some energetic, well-known, philanthropic citizen" and would include representatives from the various pressure groups involved in the field.[8] Given the presence of the major pressure groups in the field, and a chairman of some weight in the community, doubtless such a board would have become a counter-weight to the inspectorate and a major influence on mental retardation policy in the province. This was certainly the case in Great Britain, where an effective policy making role was played by the Board of Control which grew out of the 1913 Mental Deficiency Act, and the corporatist Central Association for the Care of the Mentally Defective, which represented the various voluntary organizations in the field. But one of the reasons for the appointment of these bodies was to ensure that the local governments which had the major responsibility of providing mental retardation services adhered to the provisions of the 1913 Act. In Ontario, however, nothing similar to the English 1913 Mental Deficiency Act was passed, and the provincial government was loath to establish any body that might antagonize the municipal governments. Thus, the only major structural change that occurred in the interwar period was the establishment of a Department of Health in 1923, and the appointment of a Minister of Health in that same year. Two years later a Deputy Minister of Health was appointed. The Department of Health was established because of the growth in the duties of the provincial Board of Health which had been under the Provincial Secretary until

1919, when it had been transferred to the Department of Labour.

The process of centralization was pushed even further after 1931. A committee of two Americans appointed by the Department of Health in 1937 to look into the Ontario Hospitals system observed that there were no local boards and that the Members of Parliament "may be interested helpfully or otherwise in the Department but have no specific relation to it."[9] The Department of Health had full and ultimate responsibility over all personnel through the office of the deputy minister. Appointments were made by the Civil Service Commissioner on recommendation of the Minister of Health, but no examinations were held either for appointment or promotion. The committee also observed that the overwhelming authority of the department over physicians and superintendents meant that creative or innovative people had little chance to build up their own following in the system, or to experiment with new methods. According to the committee, "genius" was subordinated to "regularity." They also noted that the local community had absolutely no say nor interest in the institution while even the MPP was excluded from any participation in the activities of the hospital. Because authority was concentrated at the top, local discipline could only be imposed and conflicts settled by invoking "distant authority." Moreover, hospital authorities were reluctant to call on the department's help in dealing with staff since the department would make the ultimate decision, but in the end it might be quite different from what the hospital authorities intended or wanted. "Medical officers seem hampered by the scheme of organization, much harassed by the type of some employees assigned to them, worried about their inability to obtain proper upkeep for their institutions, for requisitions for trivial repairs go through a maze of routine."[10] As to the hospitals themselves, the committee noted the policy of financial retrenchment had led to a situation where "lack of foresight, or indifference to the needs of the sick or the devastating financial disintegration of the depression period have brought the institutions of this generous Province to a lamentable plane of incapacity. Everywhere one finds overcrowding. Beds have been put in all sorts of unsuitable places."[11] To meet this contingency the committee recommended the construction of additional institutional facilities particularly for mentally retarded people who were "of the custodial type or who need special training for a few years."[12] At the time of their report, they noted that although Orillia's capacity was 1,500 beds, it contained 347 excess beds, 23 percent more than the institution was designed to hold. The committee also recommended that superintendents should be given more responsibility for their hospitals, that closer relations be established between Orillia and the school system, and that a Board of Visitors be created for each institution.

None of these reforms was carried out. By the 1930's the Ontario Hospital system had become a close-knit, centralized and hierarchical system that was almost immune to outside change. Despite the best efforts of the inspectors and especially of Langmuir, during the late nineteenth and

early twentieth centuries, there is evidence that local merchants and asylum employees often collaborated so that shoddy or inferior goods were palmed off on to the asylums in exchange for favours or benefits for the employees. Moreover, the medical officers and superintendents did not always enjoy a particularly high reputation in their field. There were exceptions. Joseph Workman, A.H. Beaton, and B.T. McGhie were internationally known and respected. But some medical superintendents or even some of the top politicians or bureaucrats were known to have drug or drinking problems. One person who held a professional position at Orillia in the late 1920's tells of an occasion when B.T. McGhie and the staff were eagerly awaiting a joint visit from the Provincial Secretary and the Inspector. Both arrived in a large limousine, went straight to McGhie's office and asked if he had something to drink. McGhie said he did not. Since this was during Prohibition they asked McGhie to refer them to a local bootlegger. McGhie did, and the two vanished and were not seen at Orillia again. That was the extent of their inspection.[13] Of course, such occurrences were infrequent, but the closed nature of the Ontario mental retardation system meant that the individual shortcomings or character defects of those who manned the bureaucracies went largely unnoticed. Moreover, since political reasons rather than expertise or innovative ability often dictated the choice of medical superintendent there was little possibility that new ideas would intrude upon the existing system.[14] Except for the CNCMH which was increasingly concentrating its efforts on mental health, and the inspector, there were no alternate sources of criticism or innovation. While the inspectorate had been a force to be reckoned with during the late nineteenth and early twentieth centuries, taking its role of policy analysis very seriously indeed, by the 1920's it had ceased to perform any critical function. Partly this was because of the personnel chosen for the job. The Provincial Secretary and later the Minister of Health were disinclined to choose people likely to undermine the work of the department, and while prior to the transfer of the hospital system to the Department of Health in 1930 the inspectors could claim as much right as anyone in the Provincial Secretary's office to discuss policy considerations in mental health and mental retardation, after 1930, where everybody, from the Minister on down to the inspectors and superintendents was usually a medical doctor, the inspectors could claim no more expertise than anyone else. Moreover, since the medical profession has never been known for its willingness to engage in internal criticism or reform, it was unlikely that the inspectors would want to rock the boat. In this fashion, the bureaucratic gears and wheels within the Department of Health spun smoothly and silently, isolated from the outside and from potential sources of conflict or friction.

However, the situation of mentally retarded people in Ontario in the prewar period was not completely black. By 1939 almost 3,000 mentally retarded children were enrolled in training classes within the auxiliary education system. At Orillia as well, the 1930's saw the school program

flourishing as thirteen teachers gave classes in academic as well as vocational subjects.[15] But at the same time, there were 2,383 mentally retarded people in residence at Orillia and Cobourg, another 1,390 in psychiatric facilities and an unknown number scattered throughout the municipal houses of refuge, jails or other institutions.[16] Thus the number of children in the training classes must have been close to the number of people institutionalized. The importance of this fact is that the civil servants in education had a much more positive attitude toward the mentally retarded children in the auxiliary education system than did either the bureaucrats in Health or the public toward mentally retarded children and adults in institutions.

Even though the myth of the menace of the feeble-minded had almost completely disappeared by the late 1930's, the community was unwilling to do anything either to reform the existing institutions, or to establish a system whereby mentally retarded people might be re-integrated into society. The only exception to this grim picture was the auxiliary education system. Thus, there was at this time a bifurcated mental retardation policy with an institutional aspect and an educational aspect. Each was based on a quite different set of attitudes and structures, but those surrounding the educational system were extremely important in maintaining an humanistic side to policy.

Social policy develops as a response to social problems, and social problems develop as societies define, and redefine categories of need, dependence or threat. This process is contingent, not inevitable, so that social problems defined in negative terms and evoking punitive policies may be redefined in more positive terms and evoke more beneficent policies. Or the process may reverse itself. However, the question of definition is extremely important for as the social problem is defined and as its characteristics are described, so will policy develop. Social reformers are well aware of this and a good deal of their time and effort is spent marshalling whatever available evidence exists in support of their particular definition. Definitions and characteristics of a social problem may differ from one country to another, from one state or one province to another, or competing definitions may coexist happily or unhappily within the same jurisdiction. In Massachusetts and New York State in the 1840's, idiocy was defined in humanistic terms, and the resulting policy was altruistic in structure. In Upper Canada in the 1850's idiocy was defined in negative terms (idiots were assimilated to the category of the incurably insane) and the resulting policy was initially exclusionary, and later custodial. However, throughout North America in the late nineteenth century, two competing definitions of mental retardation, and two different policies coexisted. On the one hand feeble-mindedness was defined and described in such as way as to justify the punitive, custodial and sterilization policies of the era. On the other hand, the growing faith in the humanizing and socializing powers of public education led to a different perspective so that a sub-group of the feeble-minded population,

those with IQs between 50 and 75, and between the ages of six and sixteen (the IQs and ages varied from one jurisdiction to another) was defined in positive, humanistic terms. This, in turn, evoked quite a different government policy.

Moreover, bureaucrats sometimes identify so closely with their departmental policies that they defend them from outside attack, and try to obtain support from existing or new clients. This seems to have been the case with the auxiliary education system, for the various inspectors of education held a quite different conception of the nature of mental retardation from the social reformers in the custodial movement. It was the structure and philosophy of the special education movement which provided a base from which the parents' movements of the 1940's were to launch an attack on existing attitudes and on the institutional system.

Part III

1945 to 1980

7

The Inception of the Parents' Movement

The first parents' group in North America had been organized in 1932 in Cleveland, Ohio as the Council for Retarded Children. In 1934, the Children's Benevolent League was organized by the parents of children in the Washington State institution for the mentally retarded. Because the institution was in the eastern part of the state and was separated from the west by the Cascade mountains, the parents pressured the government to construct an additional institution in the west. Once they had succeeded in this goal they decided to form a permanent, state-wide organization.[1] But these groups were exceptional, for during the 1930's the parents of mentally retarded children were made to feel embarrassed, ashamed and guilty. And even if they had tried to form some kind of association in Ontario, it is highly unlikely they would have been encouraged in their efforts by the bureaucrats in the Department of Health, or the officials at Orillia. Even in the 1950's, as one official who served at Orillia and later in the Ministry of Health put it, the assumption on the part of institution officials was that they knew better than the parents how to deal with mentally retarded children and relatives. The very procedure by which a child was admitted was enough to traumatize any parent.

A few weeks prior to admission the parents received a list of things the child would need at the institution. Then, upon arrival at Orillia the parents would be met by an attendant, or sometimes by a medical officer. The child's history would be taken down by one of the staff, an employee would take him in hand, open the large doors that led to the institution proper, and the child would disappear down an enormous corridor. The parents were not allowed to see the child until six weeks had elapsed to give him time to "adjust" to the new environment.[2] Moreover, given the immensely long waiting list with more than 1,000 people clamoring for admission, many parents had to use whatever influence they had with

their local MPP in order to jump the queue. Cowed as they were by the institutional authorities, it is not surprising that the first parents' group in Ontario was sparked not by an issue arising from institutional care, but out of a quite separate concern for educational facilities for mentally retarded children with IQs below 50.

After auxiliary classes were first established in Ontario in 1914, the Binet test was gradually introduced as a means for distinguishing the various levels of retardation. In the Binet test the maximum mental age is sixteen years, and the intelligence of those tested under this system is expressed in terms of the relationship between mental and chronological age. For example, an adult who has a mental age of eight or lower is classified as an imbecile or an idiot. Later, when IQ levels were used an IQ of 50 was one-half the average intelligence level of 100, and thus it marked the line between those who were idiots and imbeciles, and those who were morons, or dull, or borderline normal—the terms differing depending on the authority. It was convenient, therefore, to exclude all those with IQs of 50 and below from the special and auxiliary classes that were gradually being established throughout North America. For parents with children with under 50, IQ this meant that they either trained their children themselves, paid to have them trained or cared for in a private institution, or sent them to Orillia.

But the first sign of a change in policy occurred in April, 1947, when a special class for mentally retarded children with IQs under 50, and therefore excluded from the auxiliary class system, was established on the initiative of Donald Frisby, an auxiliary class teacher in Kirkland Lake, a community about 350 miles northwest of Toronto. Acting purely on his own initiative, Frisby marshalled the support of local service clubs and wrote directly to Conservative Premier George Drew asking for financial support. In March, 1947, the Department of Education responded with a grant of $2,500 per year for three years. The class opened with six pupils. Dr. Carmen E. Stothers, Inspector of Auxiliary Classes first appointed in 1939, actively supported the request for funds from Frisby.[3]

Although a local steering committee was organized to oversee the operations of the Kirkland Lake class, the actual inception of an organized parents' movement did not occur until after the publication on September 29, 1948 of a letter to the Toronto *Star* from Mrs. Victoria Glover. She wrote:

> May I say a few words on behalf of our backward children and their bewildered mothers. There is no school for such children, no place where they could get a little training to be of some use in the world, only Orillia which is always full. If these children can be taught something at Orillia why cannot a day school be put at their disposal? I am sure their mothers would gladly pay for their transportation to and from school. After all, they are paying taxes for

> other more fortunate children's schooling. I think it is time something was done for parents who from a sense of faith in a merciful providence want to keep them at home living a normal life. These are real parents, only asking a little aid and encouragement to shoulder their own heavy burden. God bless them and may the Ontario government help them and their children who might still be made something of, living a normal life and with the perfect love, understanding and guidance of such parents.

At that time, Mrs. Glover was still unaware of the Kirkland Lake experiment, but her letter evoked an instant response. A telephone call to Mrs. Glover from a man who was the parent of a retarded son led to another letter to the *Star* and then to a meeting at the United Church on Carlton Street in Toronto on November 4, 1948. Seventy people attended. Interestingly enough, when one member of the Parents Council suggested that the group should appeal to the Department of Health, the executive rejected the idea saying they wanted to get away from the "institutional" idea and that their main object was to get the Department of Education to establish day schools. In any case, on November 9 a delegation from the newly formed Parents' Council for Retarded Children met with the Minister of Education, Dana Porter, and gave him a letter which read in part: "Whereas there are many children in Ontario who are unable to benefit by the course of studies set forth by the Department of Education. . . we the parents and friends of these children respectfully urge the Department of Education to take steps in the near future to make available facilities for such education."[4] This was the first instance in Ontario of a parents' association trying to directly influence governmental mental retardation policy.

Almost immediately the Parents' Council began a campaign to bring the issue before the legislature. On March 19, 1949, CCF member Reid Scott mentioned to the Minister of Education that he had received a number of letters on the question, and wished to know the intentions of the Department of Education. Interestingly enough, the Minister seemed rather uncertain as to a future course of action. On the one hand he stated: "Up until fairly recently, it has been generally considered children in that classification should not be dealt with from an educational point of view at all, that they were not people for whom any course of education could do very much."[5] On the other hand he contended that as a result of the class established at Kirkland Lake: "There is very, very little that can be done, but we are finding as a result of the experiments . . . that a certain amount can be done. . ." After this "clarification," the Minister explained that "it has more to do with the Health Department from the medical point of view," and that he could not "say we are going to be in a position very soon to take care of all the children of this type. I think it will take a little time before we are equipped to do that. . . . Up to the last few years children of this type were regarded as being ineducable, but really that was

not a correct description of them, because there is something which can be done, but only with great care and with highly trained teachers who have to be trained along the right lines. That is why we cannot act too quickly."[6]

Since the Department of Education was clearly unwilling to move in this area, with the help of the Department of Health the Parents' Council appealed to the Department of National Health and Welfare in Ottawa. The Mental Hygiene Branch responded favorably and helped them establish pilot classes in 1949 for Toronto and York Township for children between the ages of twelve and twenty-one, but with IQs of less than 50. However, after a lapse of almost exactly one year CCF member Reid Scott once again asked the Minister of Education on March 15, 1951 what responsibility his department was willing to assume. Dana Porter replied: "Well, as I explained in other years there is an experimental school which is at Kirkland Lake and it has been carrying on this sort of instruction for some years with some measure of success. Now we are not ready yet to enter into any large program of this kind, we are not ready to do it. Methods have not yet been sufficiently proven."[7] But the Parents' Council continued to grow apace so that by 1951 the membership had reached 200 and similar organizations had begun to form throughout the province. Although they continued to ask the Department of Education to provide some funding for the schools that had been established, it was only when the new Minister of Education W.J. Dunlop took office that their efforts finally met with success. Dunlop encouraged the various groups to coalesce in a single organization so as to better present their views, as well as to make it easier for the department to deal with them. On February 6, 1953, representatives from the seven existing organizations met in Toronto and agreed to form the Ontario Association for Retarded Children (OARC). Shortly thereafter, on June 23, 1953, the Department of Education announced that the Education Act had been revised to permit the payment of $250 per pupil per year for those under 18 years of age, and attending half day classes of not more than three hours a day. Attached to these regulations were conditions concerning the frequency of meetings of OARC affiliates, and establishing for each such school a five person education committee including the local school inspector, and requiring that the group employ teachers, a principal and the services of voluntary helpers.[8]

There were a number of reasons for the change of heart. Perhaps the most important was the growing size and political influence of the OARC. By 1954 the OARC had 900 members, many of them articulate professionals, some with contacts in the provincial government. The press too was quite favorable; articles and editorials in the Toronto *Star*, *Telegram* and *Globe and Mail* during this period supported the parents in their drive to get government financial support for their schools. Within the education bureaucracy as well, there was a good deal of support from auxiliary school inspectors and teachers. During the 1950's and

1960's the various political parties competed with each other to encourage increased funding and expansion of the educational system. John P. Robarts assumed the post of Minister of Education in 1959, while William G. Davis became Minister of Education in October 1962. At the same time, the provincial economy was flourishing and since it was generally assumed that there was a correlation between a high level of education and economic prosperity, there was no lack of money for education.

This diffuse support for education in general was then converted into specific support for special education for retarded children. In addition, the OARC emphasized that since retarded people had as much right to an education as other citizens, they should not be excluded from enjoying the benefits of a system supported by all taxpayers and open to everyone. It is interesting to note that this argument was implicitly accepted after 1945, for when Minister of Education Dana Porter dithered over Parents' Council requests for financial aid for their schools, he objected on the grounds that children with IQs of under 50 might not benefit from education, not on the grounds that they did not have a right to an education.

Of course, there was some opposition to these requests. Local school boards were fearful lest they be given the responsibility for handling retarded children. Some civil servants in the Department of Education were hesitant because they felt once government funds were made available to these children, there would be no way of preventing the parents' groups from ultimately demanding 100 percent funding — a prophecy that was to prove correct.

From 1953 the number of classes and pupil enrolment increased dramatically. In 1953 grants were paid to parents' groups in 11 Ontario cities, and 260 pupils were enrolled. By 1957 grants were being paid to parents' groups running classes teaching 1,250 children. And by 1960 the report of the Department of Education mentions the "unexpected rate" at which the program was expanding. By that year local associations were conducting classes in sixty-six schools with a total enrolment of 1,949 pupils. Expenditure on the schools had risen from $44,119 in 1954 to $657,260 in 1960 ($449,965 was for operating expenses and $207,295 was for capital grants). At this time the government contributed 30 percent as a capital grant, which meant that parents had to find the remaining 70 percent elsewhere. But the government was surprised at the rapid rate of growth of the schools, for in 1960 Robarts mentioned that the unanticipated growth of the schools had led the Department of Education to review its policy.[9] However, many local associations which were running schools, or thinking about running them were coming under a severe financial strain both because of the difficulty encountered in finding the necessary capital funds as well as the need to provide for transportation costs which, at this time, were not covered by a provincial subsidy.

Within the government there seemed to be some sentiment that the province should assume full responsibility for the education of the trainable retarded. On March 21, 1961, Liberal MPP Vern Singer mentioned that

a unanimous recommendation had been made in the health committee on a motion by William G. Davis the previous year that the education of "educable retarded children be undertaken by the government of Ontario."[9] Singer's statement was a bit confused since later in the debate he amended his remarks and observed that the recommendation had been made in the education committee, and in using the term "educable" he probably meant "trainable." In any case Minister of Education Robarts mentioned that he had conferred with members of the OARC and that they had expressed "some doubt about how fast we should proceed and in what direction." And Robarts concluded his remarks to Singer by noting that "we are not going to be stampeded into a course of action that might in the long run do them more harm than good."[10]

By the following year, the OARC decided to ask its Education Committee to undertake a study of the legislation under which schools were run in the U.S. and Canada. They found a wide variety of methods, ranging from systems where the schools were operated purely and simply by the public school boards; to systems jointly operated by school boards, the local association, the Department of Education and other groups; to those where, as in Ontario, the schools were operated by local associations and partially funded by government. The committee concluded that the best system was one where the public school boards ran the classes. As a result of this study the Board of Directors sent a memorandum to the Premier and the Ministers of Education, Health, and Public Welfare stating: "It is the belief of this association that parents are entitled as taxpayers to such training and education as each child can absorb as the responsibility of the local school system assisted by appropriate grants from the government. . . . It is now the feeling of this association that a step by step plan should be introduced working gradually towards the complete assumption of this responsibility by appropriate local authorities."[11] The Board also recommended that meanwhile the government move quickly toward 100 percent funding of the children from local taxation and through the local school boards. One issue that was not explicitly raised concerned who would take over the school buildings owned by the various local associations.

The government was amenable to this idea, for on March 25, 1963, Minister of Education Davis announced an increase in the capital subsidy from 30 percent to 50 percent and added: "These changes which are being made immediately are only steps in the long-range plan under which local associations for retarded children will be relieved of any responsibility for raising funds for the operation of a school for retarded children between the ages of five and eighteen."[12] The next step occurred in 1965 when the government passed Bill 131 creating the Retarded Children's Education Authorities which took over responsibility for operating the schools from the local associations. The new authority consisted of two representatives from the local associations and four representatives appointed from the municipal government. The latter were appointed be-

cause under the new arrangement the provincial government provided 80 percent of the operating costs of the school, with the municipality contributing the remaining 20 percent. But as the demand for new schools continued, it was still incumbent upon local associations to find the 50 percent capital funds that were necessary before the province would agree to provide the matching 50 percent and get the school under way. By this time, however, local associations had become involved in the establishment of sheltered workshops and even group residences. In addition, some local associations now faced requests for additional school construction in their districts. As a result, in late 1966, the Board of Directors of the Ontario Association for the Mentally Retarded (OAMR-the name had been changed in April 1965) sent a letter to Minister of Education Davis asking that the capital grant funding for school construction be increased from 50 to 80 percent.

At this time, Davis and the civil servants in the Department of Education were studying ways to bring the schools completely under the aegis of the Department. Within the OAMR, however, there was a good deal of resistance to the idea of incorporating the association's school system within the public education system. Many parents had first organized their local associations in order to establish and staff a school. Some of them had served as teachers during the early years. And many parents felt that teachers employed through the public school system would lack the emotional commitment which they believed was characteristic of the teachers they had hired over the years. Eventually, however, the Department of Education entered into discussions with officials from the OAMR over exactly what form the transfer would take and what the new system would look like. But, one official from the OAMR recalls: "There was resistance at first. A lot of people had to be kind of talked into it . . . and the first time it came up a lot of people thought it was a lamebrain idea. . . ." Exactly how many OAMR members opposed the transfer is difficult to say, estimates range from 50 to 75 percent. Moreover, resistance increased as it became clear that the government intended to take over the school buildings that had initially been built by the local associations, either fully or partly with their own funds, often with their own labour. The same OAMR official commented: "They worked day and night, and they taught, and they did the caretaking and they built the furniture. They begged, borrowed and stole to get the equipment in. So they felt very much that this was unfair for it to be taken away from them."[13] In addition, many parents felt the raison d'être of the parents' groups would disappear once the schools were turned over to the government.

Another reason for hesitancy had to do with the politicization of the school boards. Initially, when the local parents' associations had run the schools there was a great deal of flexibility about which children would be admitted. Under government regulations however, the lower age limit for admission for full day attendance was 10. However, a student whose IQ was over 50, or, to cite the Department of Education's criterion,

"whose mental capacity was not incapable of development beyond that of a child of normal mentality at eight years of age," was sometimes admitted when the parents' groups had control. But when the municipal representatives were appointed to a majority on the new authorities created in 1965, questions of cost control and adherence to provincial standards were often of greater importance to them than to the parents. Thus, when the time came for the OAMR to vote on the change, as one of the government officials present at the meeting put it, "they really roasted us." His impression during the question and answer session at the 1968 meeting was that the delegates were going to vote against the resolution supporting the complete takeover by government. In the end, however, there seemed to be a change of sentiment and the resolution was accepted with overwhelming approval. As a result, on January 1, 1969 the schools operated by the Retarded Children's Education Authorities were taken over by the public school system, and for administrative purposes were incorporated into the secondary school system as "Schools for Trainable Retarded Children."[14]

Why and how did this decision come about, and in precisely this way? Certainly the political climate was favorable to such a decision, but so too was the economic climate, for the parents' groups were benefiting from a steady increase in government expenditures that had seen a rise from 2.7 percent of the Gross Provincial Product in 1945/46, to 5.7 percent in 1960/61, to 15.2 percent in 1970/71. Education in particular had benefited from government largesse, for since 1946 there had been a constant rise in total per capita expenditures from the municipal and provincial governments, and, after 1949, from the federal government.[15] In 1946 per capita expenditure in 1971 dollars in Ontario was $67, by 1959 the figure had reached $95, by 1961, $157 and by 1969, the year of the takeover, per capita expenditure on education in Ontario had reached $288. Many of those interviewed, from government ministers on down agreed that there was a good deal of money available in the 1950's and 1960's for education and that this played a major role in sustaining a positive attitude toward the incorporation of the association schools into the public school system. In addition, the population of Ontario was growing rapidly and was getting younger. In 1921 the population was 2,933,662, in 1931, it was 3,431,683, an increase of 14.5 percent; in 1941 it was 3,787,655, (up 9.3 percent), in 1951, 4,597,542, (up 17.6 percent), in 1961, 6,236,092 (up 27 percent) and in 1971 it reached 7,703,105, an increase of 19 percent. Not only did this mean an increase in the absolute number of mentally retarded people, but the population had grown younger between 1941 when the age cohort between 0 and 14 comprised 24.4 percent and 1966 when it comprised 31.7 percent of the total.

Moreover, parent group pressure on government to give access to the educational system to those mentally retarded children who had hitherto been barred was occurring almost everywhere in North America. In 1955 in New York State, for example, permissive legislation had been passed

allowing local school districts to receive state aid if they established special classes for children with under 50 IQ. By 1961 after a relentless campaign by the Association for the Help of Retarded Children, Governor Rockefeller signed a bill requiring public schools to open special classes for trainable mentally retarded children with under 50 IQ. Although this step was eight years in advance of Ontario, by 1968 there were only 5,700 trainable children in classes in New York State with a population of 18,023,000 as compared with 4,500 children in classes in Ontario with a population of 7,262,000.[16]

Unlike the situation in New York State where the civil service and the politicians were divided over opening special classes for the trainable mentally retarded, the OAMR had the support of both the civil service and the major political figure involved, Minister of Education William G. Davis. Indeed, civil servants were behind two schemes designed to avoid some of the major obstacles that might have been raised to oppose the schools' transfer in 1968: the local school boards' reluctance to assume new administrative and financial obligations, and objections from the separate schools' supporters who might have argued that they too should have the right to establish separate schools for Catholic trainable mentally retarded children. The first obstacle was avoided by transferring the schools at the same time as a province-wide reorganization of the school boards. Since the new regional school boards did not yet exist there was little chance of opposition. And the problem with the separate schools was avoided by putting the new advisory committees in the secondary school system. Since the separate school boards were not allowed to operate secondary schools, the possibility of their wanting to create their own schools for retarded children was thereby diminished. Moreover, once the support of the Minister of Education had been obtained, there was little difficulty in getting the legislation through the Cabinet. This was quite different from the New York situation where the legislature had passed bills supporting mandatory schooling for trainable mentally retarded children, only to have the Governor veto the legislation. By contrast, the OAMR could concentrate its pressure on the bureaucracy and on the Minister and hope that once these two had been convinced, the battle was nearly won.[17]

One question that has been raised within the OAMR is whether or not it was the intention from the very beginning to turn the schools over to the government, or whether the transfer came about in an ad hoc, unplanned fashion. In 1976 the OAMR commissioned a number of policy analysts to look at the future role of the OAMR in the light of its history. As part of their retrospect the analysts studied the schools' transfer issue and concluded that: "It does not appear that there was any intention to develop an isolated, separate system of education or services for retarded children. Rather, there was the intention to convince the government by means of demonstration that educational opportunities should be made available to retarded children in much the same way that opportunities

were made available to other children." In a footnote, however, the authors observe that some of those interviewed for their study disagreed with this point, and felt that the "rationale was an afterthought. The intention was to provide education."[18]

The danger here as in any discussion of social policy, is of falling into the *post hoc ergo propter hoc* fallacy. Because the eventual outcome of the parents establishing their own school system was the transfer of that system to the government does not necessarily mean this outcome was intended from the very beginning. What seems to have happened is that the parents' desire to extend the range of services available to mentally retarded children ran into conflict with their emotional commitment to the schools they had founded, built, and helped staff. Many of them would probably have agreed with the English social policy analyst Marjory Fry who said: "You can't give children love by Act of Parliament."[19] Those who were able to resolve this conflict were willing, albeit reluctantly, to turn the schools over to the government. Others who could not, opposed the transfer. As the staff of the OAMR recognized, however, it was becoming increasingly difficult to continue to fund the schools as well as the whole range of other activities in which the associations were becoming involved. For a service as extensive and as expensive as a school system, even one as small as that for trainable mentally retarded people, trained help and massive financial support is necessary. As the English social policy theorist Robert Pinker has observed: "The existence of vast welfare bureaucracies in industrial societies suggests not so much that these societies are uniquely compassionate, but is a recognition of the fact that the spontaneous dictates of compassion consistently fail to meet the volume of unmet human needs."[20]

Of course, there is nothing inevitable in a process which begins with a private organization like the OAMR funding and administering services, and ends with government funding and administration. There are a myriad of hypothetical alternatives from one where the government provides partial funds and has no say in administration, as was the case during the early stages of the school program, to a system where the government provides 100 percent funding but leaves administration entirely up to the voluntary organization. The first alternative puts an immense strain on the voluntary organization while the second assumes a government which is willing to dispense funds without asking for any control over the administration of those funds. The latter alternative is highly unlikely. The dispensation of government funds and the imposition of control measures almost always go hand in hand. Thus it really does not matter what the original intentions of the members of the OAMR were. Whether it was intended from the beginning or was merely an ad hoc process that evolved as it went along, the larger the role government played in funding the school system, inevitably, the larger the role it would take in the administration of the school system. Moreover, as the policy analysts mentioned in their 1976 study: "By and large, the transfer was

not really alien to the policy framework of the Department of Education which had developed the public school system and had never been too partial to the system of separate education."[21]

The OAMR's success in getting the government to take over the schools also illustrates another aspect to the evolution of mental retardation policy. In writing about the poor Georg Simmel has pointed out that: "Where assistance to the poor has its raison d'être in an organic link between elements, the *rights* of the poor are more highly emphasized. . . [his italics]."[22] But in order for a deviant group to have rights, it must be conceived of as fully and completely part of society as a whole, its members must be thought of as citizens deserving of the same social benefits as every other citizen. Before 1939, mentally retarded people were thought of and generally treated as a group inferior to and apart from the rest of society. But the war helped to reorient attitudes toward mental retardation. We should not forget the well-nigh universal horror and revulsion that occurred in the West when the news of Hitler's concentration camps seeped through. Not only were Jews, Gypsies, Eastern Europeans and a variety of other peoples slaughtered for no other reason than their race or religion, it was revealed that the Nazis had engaged in the mass murder of mentally retarded people as well. Moreover, the Nazis had adopted, and perverted, eugenic arguments to justify this killing. People were shocked to realize the deadly potential inherent in some of the arguments that had been used in the 1920's to justify the incarceration and sterilization of mentally retarded people. For the first time large numbers of people began to argue that mentally retarded people should have the same rights and privileges as other members of society, and that to characterize them as somehow less than full citizens was to put their very existence in danger.

There was a second major change as well. The period after 1945 was characterized by a great wave of social reform in the West, particularly in Great Britain but equally in Canada and the United States. Millions of ordinary men and women had not spent years and risked their lives in the armed services only to return to an inegalitarian social and economic system. Many were determined to expand the notion of citizenship to include certain social, as well as political rights. In these circumstances, it is not surprising that the parents and relatives of mentally retarded children began to demand services from the government not as charity, not as a means of getting rid of their children, but rather as a right owed to them and to their children as full citizens of the postwar era.

In this context it is interesting to see how the OARC and later the OAMR emphasized the organic link between mentally retarded people and the rest of society in order to sustain the notion that mentally retarded people had the same rights as other citizens. Pamphlets and posters produced during the 1950's and 1960's by both government and the OARC almost always include pictures of smiling children with smiling parents.

Although one or two of the children seem to manifest the characteristic traits of Down's Syndrome, most of them look perfectly normal. In some cases the children's faces cannot be seen or are partially obscured by the angle from which the photograph is taken. Now it is quite true that not all mentally retarded people look differently from other people. But many do. Quite obviously those who were working for mentally retarded children and adults during this period were intent on emphasizing the similarities rather than the differences between mentally retarded people and non-retarded people.

Thus, whether it was due to revulsion against the Nazi crimes of 1939–1945, or to the activities of the various parents' associations or to the publicity campaigns of the OARC and the provincial and federal governments, most of those who were interviewed agreed that there was a new feeling of acceptance and support for mentally retarded children during the post-1945 period. This made it much easier for the OARC to put its case to government. Since 1914 the Ontario government had accepted responsibility for the education of a variety of handicapped and disabled people through the auxiliary class system. In these circumstances the Department of Education could not raise theoretical or ideological objections to the proposal that children with IQs of under 50 should be included in the public school system. The only objections that were raised were couched in terms of cost, the ability of the children to profit from education or the problems that might arise in the administration of the system.

8

The Institutions and Their Critics

From the 1930's to the immediate postwar period absolutely nothing changed with regard to mental retardation policy. Although the government held the line on constructing additional institutions both because of lack of funds during the Depression and because of the priorities of the wartime years, pressure for additional space continued to mount. In the Throne speech of February 15, 1945, the newly elected Conservative government of George Drew announced: "Overcrowding in the mental hospitals of the province continues to be a cause of great concern. . . . An addition to the hospital at Orillia is now nearing completion and new hospitals in other parts of the province will be part of our postwar programme."

One of the new hospitals referred to was a massive facility constructed at Smiths Falls, 35 miles from Ottawa in the eastern part of the province. Located in an area of high unemployment, the facility was originally scheduled to hold 2,400 patients, but its ultimate capacity reached in the 1950's was 1,200. Originally called the Eastern Hospital for Defectives, construction work began in the early 1930's but the project was canceled in 1934 and the land sold in 1937.[1] However, the idea was revived after the war, and the institution was built in stages, with the first wing opening in January 1951. The result was a massive custodial institution whose design recalls the madhouses of the eighteenth and nineteenth centuries.

A main corridor running the length of the institution was over one-third of a mile long, while on either side in a series of "H's" aligned side by side were the various dormitories. The cross corridors were one-fifth of a mile long. A series of pavilions radiated out from the main corridor, with three pavilions for men on one side, and three for women on the other. A photograph in the Report of the Department of Public Works

for 1951 shows a ward cubicle containing six beds. In the photograph the beds are so close to one another that the chairs between them have been turned sideways. The distance between the beds appears to be about two feet.

As Wolf Wolfensberger, one of the leading American scholars of mental retardation has pointed out, architecture is a language, and that language expresses a philosophy and a point of view.[2] Although one does not have to agree with Wolfensberger that custodial style institutions express a view of the retarded person as a subhuman organism, his description of the "abuse-resistant" style of architecture can certainly be applied to Smiths Falls. Among its features are: "Walls, floors, etc. made of material that is indestructible; unbreakable, shatterproof or wire enmeshed glass in windows and partitions, installation of the sturdiest, most heavy-duty furniture and equipment, minimization of moving parts, high ceilings with recessed or specially shielded or laminated light fixtures to minimize damage due to throwing of objects, soundproofing to muffle the sounds residents are expected to emit." Other typical features of the custodial institution of this type are isolation from the surrounding community, segregation of the sexes, and buildings designed both for the convenience of the staff and for efficiency in dealing with, rather than interacting with the patients. On all counts, the Smiths Falls institution was the very model of a custodial institution. Yet, other models were available. For example, Letchworth Village, an institution consisting of small cottages had first been opened in New York State in 1911, while as recently as 1940, a new institution at Southbury, Connecticut had been opened on the assumption that "the traditional large congregate institutional units must give way to an institutional plant that would parallel, as closely as possible, a normal community; for it is to house largely children and 'children have the inalienable right to be reared in conditions approaching as closely as possible those of a normal home and community'."[3] In Ontario, however, the authorities continued to operate on the basis of philosophies and structures inherited from the nineteenth century.

By the 1950's governments all over the western world had become increasingly concerned with the financial and social burden imposed on the health service by mentally ill and mentally retarded persons. In Ontario in 1951, for example, there were 15,969 patients in the fourteen Ontario institutions for mentally ill and mentally retarded people and 13,799 in the general hospitals. Moreover, the mental hospitals and hospital schools (for mentally retarded people) were overcrowded, underfunded and understaffed. The report of the Ontario Hospital Survey Committee for 1951 noted that there was an average 22.4 percent overcrowding at the Ontario Hospitals, that there were only thirty-seven psychiatrists in private practice in the province, and that 2,500 children under the age of sixteen were awaiting admission to Orillia. In view of the obvious inadequacy of mental health facilities in the province, the committee recommended the addition

of thirty-one community health clinics, 157 psychiatrists, and 11,416 additional mental hospital beds. The committee also recommended that mental health units be established in general hospitals for patients with "less severe forms of mental illness," and that the 1,100 senile patients in the various mental hospitals "be cared for in a special type of institution suitable for aged persons only." The committee also noted that mental patients who were able to pay were assessed a minimum maintenance payment of $7.00 per week in most of the Ontario Hospitals, and that under laws dating back to the 1930's, municipalities also contributed a modest sum for every indigent patient from the municipality in Ontario Hospital. But the committee looked forward to the day when treatment would be free.[4]

At this time there appeared to be a general consensus about the need to increase the number of beds for mentally ill and mentally retarded persons. The government had already opened the new institution at Smiths Falls, and in 1952 regulations at Orillia were changed to permit the admission of children under six. In 1951 facilities for between 200 to 300 children were under construction there. By 1955 this was found inadequate and a further 300 beds were added.[5] Even the opposition parties in the legislature criticized the government for not moving fast enough in providing additional space. On March 27, 1956, CCF member Donald MacDonald said to the Minister of Health, MacKinnon Phillips: "It seems to me, if we are going to meet the needs of these tragically unfortunate people in our society, we might as well recognize we can meet their needs in a sensible, rational, intelligent way, only by expanding the institutions we have, which will cost more money." The Minister responded by noting that the province had already provided 1,600 new beds at Smiths Falls "which is identically the same type of hospital as at Orillia, except for its modern design" and that there was money in the estimates to start a new hospital in southwestern Ontario."[6] The Minister was here referring to the hospital at Cedar Springs about 45 miles west of Windsor. The original plan was to start with 1,200 beds by 1960 and gradually expand to a total capacity of 2,000 beds.[7] The Cedar Springs institution was a carbon copy of the Smiths Falls design, but when finally completed, a number of buildings included in the original plan including a recreation building were omitted and the institution never held more than 1,000 people.

At the same time as the province was moving ahead with a massive building program for mentally retarded people, doubts were being expressed about the wisdom of establishing new institutions for the mentally ill. The actual rate per 100,000 population of patients resident in Ontario mental hospitals had been falling in an erratic fashion since 1938, but more steadily since 1948.[8] In the 1950's increasing stress was put on community clinics and on out-patient services for the mentally ill. The notion of the "therapeutic community" had made its appearance and proponents of this concept argued that in order to treat mental patients effectively existing hospitals should be sub-divided into smaller, semi-

independent units where every aspect of hospital life would be integrated into a continuous program of treatment.[9] Experience with mental hospital programs in Scandinavia and in Great Britain seemed to indicate that community treatment of the mentally ill when combined with an integrated system of community facilities was effective in reducing the hospital population. Echoes of these findings were heard in 1958 in the Ontario legislature when CFF MPP Donald MacDonald asked MacKinnon Phillips: "Does the Government still feel that the answer to this problem is building big hospitals of the size of the one, for example, that we have just opened at North Bay [with a capacity of 1,100 patients] when all the experts in the field argue that precisely the opposite kind of approach should be taken—community hospitals no bigger than a few hundred beds?"[10] Then MacDonald went on to cite the example of Denmark where mental hospitals were being reduced from 1,000 to 800 beds, to 500 to 400. The Minister of Health replied that he had recently lunched with Clarence Hincks of the Canadian Mental Health Association and they had both agreed that the smallest psychiatric hospital should have 600 beds. To reduce the size further than that would impair efficiency since the same services needed to supply a hospital of 200 to 400 could equally well be used for a hospital of between 600 to 800 patients.[11] But Phillips admitted that institutions the size of Orillia and Smiths Falls were probably too large.[12]

Dr. Dymond's Magna Carta

It was only in 1958, when Dr. Matthew Dymond took office as Minister of Health that the government began to articulate a new approach to mental health and mental retardation policy. Upon assuming office, Dymond was handed a new series of policy proposals drafted by W.G. Brown, Deputy Minister of Health and B.H. McNeel, Chief of the Mental Health Division.[13]

The authors begin with a brief critique of the asylum system and of the central role played by the large, isolated and "indestructible" institutions. "If we could start afresh, our organization of Mental Health Services would start at the community level. Up to the present, we have been working backward trying to bring the mental hospitals closer to the community and this is the course that, by force of circumstance, we will have to continue, though hopefully at an increased rate." The authors then go on to propose the establishment of a regional basis for mental health services through psychiatric units in general hospitals, regional mental hospitals, hostels and infirmaries and some form of community care for "convalescent patients." In line with the therapeutic community concept they advocate breaking existing mental hospitals into smaller units of 250 to 300 beds, and the appointment of an architectural committee to look at existing and future structures. Despite their advice about the desirability of community care, however, most of the proposals centre around providing more services within a hospital setting. As regards mental re-

tardation policy Dr. Brown and Dr. McNeel admit that an inter-departmental committee with representatives from the Departments of Health, Education, Welfare, and Reform Institutions had not functioned effectively "due to lack of accurate information" and because of the scarcity of experts in the field. Nevertheless they propose for immediate action the provision of additional accommodation to relieve overcrowding at the existing Hospital Schools, the establishment of a "screening and research centre in western Ontario" and speeding up the construction of the Cedar Springs Hospital School. Although the report also contains some recommendations for community care and employment, these are vague and obviously less important, in the authors' eyes, than the necessity for more beds.

This report then became the basis of Minister Dymond's "Magna Carta" on mental health policy presented to the legislature on February 11, 1959. In his speech Dymond repeated much of what was contained in the Brown and McNeel document. He criticized the provincial tradition of dealing with mental health by building enormous, custodial institutions as starting "at the wrong end of the problem. . . . We want to try now to completely reverse the old order, to begin treatment where it should begin—at the home level, and direct that treatment toward keeping the patient in, or at least near, his home community." Dymond then argued that every large community should have a comprehensive service for mentally ill and mentally retarded people, and he listed the various policy proposals contained in the Brown and McNeel document.

As regards mental retardation policy, Dymond announced that a centre for the assessment of mentally retarded children would be developed under the supervision of a specialist who had just been selected. The centre Dymond was referring to became the Children's Psychiatric Research Institute at London (CPRI), and the director became Dr. Donald Zarfas, formerly a physician at Orillia, and the son of the former Bursar of that institution under B.T. McGhie. Zarfas was later to play a key role in shaping mental retardation policy during the 1960's and early 1970's. Dymond repeated the point about the scarcity of experts in the field, but he also noted that his department was trying to extend its program for mentally retarded persons by providing additional diagnostic and assessment facilities, facilities for nursing care and training programs, counselling services, sheltered workshops, as well as facilities for the care and supervision of mentally retarded people in the community. He also noted that some mentally retarded adults "who are completely out of their element" had been moved from Orillia. Dymond did not say where they had been moved to. He also noted that construction of Cedar Springs had been speeded up although he ultimately decided Cedar Springs was going to be much too large and he stopped construction when the institution was half built.[14]

But there was no sign of any new thinking about mental retardation. Moreover, by referring to the 6,500 "mental defectives" as "chronic"

Dymond was not only echoing a view that had affected mental retardation policy since its very inception, he was clearly implying that the best place to care for retarded persons was in a hospital or a nursing home setting. Although Dymond did initiate a modest program of rehabilitation, he remained skeptical of the possibility of returning mentally retarded people to the community. Indeed, during Dymond's tenure as Minister of Health from 1959 to 1969, and, it might even be argued, for some time after that, an enormous amount of rhetoric emanated from the government about the need to re-orient mental retardation policy away from the big custodial institutions toward some form of community care, but the reality was quite different. Certainly there were changes in policy over the ensuing years, but at no time did the government provide either the leadership or sufficient funds to establish adequate, let alone comprehensive community facilities or services for mentally retarded people. Moreover, almost every major change that occurred was the result of outside pressure emanating either from the OAMR, from the press, or from opposition attacks in the legislature.

One of the first, and most dramatic attacks on government policy occurred not long after Dymond's statement to the legislature on mental health and mental retardation policy. The precipitating event was Pierre Berton's visit to Orillia on December 31, 1959, the publication of his article in the Toronto *Star* on January 7, 1960, and CCF MPP Donald MacDonald's visit on January 8. When reporters besieged Minister of Health Dymond for a comment on the accusations of poor conditions and overcrowding, Dymond admitted that much of the criticism was true. He noted, however, that Berton's figures on Orillia were slightly wrong since the buildings were meant to house 1,900 people, not 1,000 as Berton claimed, while they actually housed 2,410, not 2,800. But the controversy over Orillia was further heightened when Dr. Foster C. Hamilton, the superintendent at Orillia charged that 50 percent of the overcrowding at Orillia was caused by MPPs who applied pressure to get children admitted to the institution. "After forty-one years I'm now on the last lap and maybe I'm free to speak out. . . . It's a political racket and everybody knows it. First, I get a letter from the parents. Then I get one from the local MPP. Then I get one from the Minister's office if the child hasn't been admitted by that time. It doesn't seem to matter whether we have beds. In one case I was told by the parent he would bring in a bed himself. The pressure never ends."[15]

For a few weeks the brouhaha died down, but it flared up again when the legislature convened in February. Although Donald MacDonald was sharply criticized for his remarks to the press in January, even Conservative MPPs admitted that the charges of overcrowding at Orillia were true.[16] Other MPPs also attacked Ontario's mental health system. James B. Trotter, a Liberal, mentioned a report from a "world mental health organization" which described Canada's mental health services and facilities as "inadequate." Trotter also noted that the organization recom-

mended that no more large hospitals or additions to existing large mental hospitals be built in Canada, and that mental hospitals should contain no more than between 300 to 500 patients.[17] The following month the CCF returned to the attack as Ken Bryden criticized the Department of Health for continuing to build "custodial" institutions rather than putting resources into "active treatment and . . . research."[18] In his reply Minister Dymond agreed with Bryden that there had previously been an undue emphasis on building new institutions, and he noted that in 1953 the health boards which operated the provincial sanitoria had plans for constructing new buildings to meet the expected increase in patients over the next few years, but on the advice of officials who expected the advent of new drugs and a consequent decline in TB would obviate the need for new sanitoria, Dymond had refused to give the go-ahead.[19] In fact, the number of TB patients dropped precipitately. Dymond then cited the growth of community clinics as an example of his department's effort to keep people out of institutions. But Dymond's remarks concerned mental health rather than mental retardation, and in this area Dymond had little new to say except to reiterate his hopes that the research institute at London might help to make possible some greater "control of mental retardation by prevention." After some further discussion of mental health programs in the province Donald MacDonald read a letter published in the January 9th edition of the *Globe and Mail* from a Dr. Dixon criticizing the custodial nature of Ontario's mental hospitals, and the appointment of psychiatrists to administrative duties at those hospitals rather than using them for actual clinical or therapeutic work. After some additional comments from Conservative MPs, Premier Leslie Frost was stung into action. "May I ask my hon. [*sic*] friend," he said to MacDonald, "if he appreciates the fact that the province of Ontario, his province, is leading America in the treatment of mental diseases? Mr. MacDonald: It is not, it is not. Hon. Mr. Frost: Well, I say it is. Mr. MacDonald: It is not. Hon. Mr. Frost: Well I say it is." After some further remarks the following exchange took place. "Hon. Mr. Frost: May I say Mr. Chairman, that this province has the widest and the most imaginative treatment and policies in connection with the treatment of mentally ill people in America. Mr. MacDonald: It has not. Hon. Mr. Frost: And it has the finest system in America. Mr. MacDonald: It has not. Hon. Mr. Frost: Furthermore, I would say that it has the most forward-looking policy— Mr. MacDonald: Tra la, tra la—"[20]

In 1958, the OARC had written its annual brief for presentation to the government. By March, 1959 they had met with the Ministers of Health, Education, Public Welfare and the Provincial Secretary to discuss the brief, and then on June 12, 1959 they had met with Minister of Health Dymond to discuss the establishment of what later became the CPRI. In the light of subsequent developments the final draft of the brief to be presented to the Premier and the Cabinet seems quite harmless when compared to what was happening in Great Britain and in some places in the U.S. For example, the OARC merely restated existing criticisms about

overcrowding at Orillia and Smiths Falls, and asked for the provision of new space. Their suggestion was that two unoccupied pavilions at the Beck Memorial Sanitorium outside London be converted for the care of 290 mentally retarded people, and that a program of constructing prefabricated and "pre-planned" steel buildings be embarked upon to provide additional space, for "perhaps 600 patients." Looking ahead, the OARC brief noted that the natural increase in the number of mentally retarded people in the population would require not only the construction of two 1,200 bed institutions, one at Cedar Springs (then under way) and another planned for Goderich, but three other institutions of the same size by 1966. The delegation also noted that "to balance the Hospital Schools however, there is need for broader community provision for the retarded." Not only would community facilities save money, "from the human point of view too, the maintenance of retarded children in the warm environments of their homes, secure in the affection of their families while young is a desirable objective." Finally, the delegation asked for the appointment of a select committee of the legislature to investigate the whole question of mental retardation and mental retardation policy. And the delegation mentioned the "impressive legislative progress in New York State during the past two years resulting from the work of a similar legislative committee."[21]

But when the delegation finally met with the Premier and his Cabinet on November 16, 1960, they got an unexpected reaction. One member of the delegation recalled the meeting. "We took this brief up and several of us went in. I can still see this meeting in the Cabinet Room. Minister of Education Robarts, I remember, was sitting not at the table but behind us, and the whole bloody Cabinet was there. And Dymond was there and we were at the table, and some of the members of the Cabinet were around behind us, and there was an outer ring of those who weren't taking any part. The Premier came in and we all stood up. He beamed at us all, and we sat down. He said 'Who is going to present this brief?' We had decided that we would take turns reading it because it was so terribly long." But before the first speaker could get very far, Frost interrupted to ask a question about mental retardation. "And that was the last word we ever read of the brief. He kept asking questions that sort of just meant to obfuscate and get us off the track . . . he just lashed us up and down the place for our attitude, approach and everything else. . . . Frost took the attitude that we were just knocking, knocking, knocking, that we never gave them any credit and so on."[22] On December 5, 1960 a Liberal MPP read a portion of the *Globe and Mail* report on that meeting into the record. The Premier was obviously upset and responded: "There has been a mistake. There must be a mistake somewhere." But Liberal James B. Trotter attacked the lack of hospital space for retarded children and blamed it not on an uncaring public but directly on the Premier. And in defending the OARC Trotter observed: "They are not of any political party, they do not wish to get involved in party politics, but they are most

anxious to help the children who do need help and are most anxious to bring it to the attention of this government."[23]

According to a number of people who were involved in this controversy, both in the OARC and in government, it was true that Frost was hostile to the OARC and unreceptive to their demands. On the other hand, Minister of Health Dymond was supportive of the OARC. One of the participants at the meeting between the Cabinet and the OARC said, "Dymond stuck up for us. Dymond was very good. He popped up and he said, 'Well I'm sure sir, I'm afraid that you are misunderstanding the attitude of the Association because my staff have had the greatest cooperation with them'."[24] It was shortly after this meeting that Dymond agreed on the production of a film called "One on Every Street" concerning mentally retarded children and their treatment in institutions. Unlike many propaganda films, "One on Every Street" showed not only the good, but the bad side of institutional life, and it was positively received by the OARC. Despite the claims of some OARC members, however, there is little question that the Association's major complaint was still that the government was not providing enough institutional space.[25] Dymond's response was to accept the complaints about poor conditions and overcrowding and to meet the problem by promising to build more, although scaled-down institutions and to improve conditions in existing ones. Yet, it would be a mistake to read into this kind of policy a self-conscious commitment to what became known later as deinstitutionalization and community integration. Although there were a number of people who were beginning to think in terms of scaling down the size of larger institutions, and establishing sufficient residential homes and community facilities to accommodate mentally retarded people released from institutions, this view had not yet been accepted by the government.[26]

Mental Retardation Policy as Welfare Policy

Dymond still conceived of mentally retarded people as suffering from an incurable, chronic condition that would necessarily prevent them from returning to the community. And he observed that there were already difficulties getting the community to accept former mental patients, but that with retardation "the problem is infinitely worse because clinically we cannot do a great deal for them. . . . Now, if a community or if a neighbour objects to a home being used for this sort of thing [a boarding home] we cannot change the situation by legislation, and we cannot change it by wielding a big stick. We hope to, and we try to, change it by a matter of education."[27]

It is impossible to say whether another political party in Ontario, either the Liberals or the NDP would have acted differently than the Conservatives in trying to get communities to accept residential facilities for mentally retarded people, but one of the major characteristics of the Progressive Conservative government during this time was a great reluctance to use legislation to accomplish this end. While the Tories were quite wil-

ling to pay 100 percent of the cost of residents of mental retardation institutions, and, ultimately, to include the local mental retardation association schools in the public school system, they balked at what seemed to them to be a social welfare program. It is significant that when the Homes for Retarded Children Act of 1962/1963 and the Homes for Retarded Persons Act of 1966 were implemented they both came under the aegis of the Department of Public Welfare. In commenting on the 1974 transfer of mental retardation services to the Ministry of Community and Social Services, Dr. Dymond said: "It is not a matter for welfare. As a physician, my attitude towards these people, the attitude of my profession, is to give people a hand up, not a handout."[28]

For the Progressive Conservatives, therefore, every citizen had a right to a free and public elementary and secondary school education, but beyond education there was a question as to how far the government was obliged to go in aiding dependent citizens. Certainly one of the oldest traditions of government in Canada, as elsewhere in the West, is to provide some kind of public care for mentally ill and mentally retarded persons. In Canada the principle extends back to the 1840's. But except for a brief period after the construction of the PLA when a serious attempt was made to provide a very high level of care for the mentally ill on the assumption that they would be cured, policy has been 'residual' in nature. It was assumed that "social welfare institutions should come into play only when the normal structures of supply, the family and the market [broke] down."[29] Thus, the obligation to provide care was not unlimited. In order to ensure that people would rely on their own resources first before turning to the government, a lower level of care was provided in public institutions as compared with that of private institutions. Whenever possible, patients or their relatives were expected to contribute to their maintenance expenses while long waiting lists acted as a further deterrent to use. Nor is it a question of whether this policy was conscious, an intended or unintended consequence of existing policies. Of course, governments sometimes set out to achieve certain goals and then find to everyone's surprise that policy is achieving quite different, and often quite opposite goals to those intended. But at that point government can choose between correcting the initial mistakes and re-directing policy in the intended direction, or of doing nothing. At this time, the government chose to temporize.

For more than a century in Ontario there had been complaints about overcrowding, understaffing and underfinancing at the mental health and mental retardation institutions. For at least thirty years it had been realized that only the establishment of community facilities and services would stem the flow of people to the big institutions. Yet, for more than a century the government had done little to correct the glaring defects in policy. By the 1960's, at a time when the provincial and federal governments were beginning to lay down the principle of free and equal access to medical care for all Canadian citizens, the government of Ontario was extremely

careful not to imply that the universalistic principles which underpinned medicare would apply equally to the care of mentally retarded people. Rather, as regards institutional care, and especially community care, mental retardation policy in Ontario would be based on the residual, selectivist principles which have always characterized welfare policy.

Despite Dymond's good intentions, complaints about overcrowding, understaffing and underfinancing at the various mental retardation institutions continued. Both the Liberals and the NDP continued to attack the government's policy in the legislature, while the OARC continued to exert pressure from the outside. In order to arrive at some kind of common policy an interdepartmental committee on mental retardation was appointed in 1962 with representatives from the Departments of Education, Health, and Public Welfare.[30] In August, 1963 the committee submitted a thirteen page report to the various Ministers. It begins by admitting that there were serious problems with existing policy and that there were increasing demands for the government to provide more services for mentally retarded people. "The Government is faced with demands for a cradle-to-the-grave program for all mentally retarded, and for standards of care and training which it is not possible to provide within the existing pattern of services without a massive increase in staff, buildings and equipment. The actual situation is that a cradle-to-the-grave program is provided for those who in effect become wards of the Province by virtue of admission to Ontario Hospital Schools."

The use of the term "cradle-to-the-grave" is rather interesting in this context because the term usually refers to the array of social services provided to citizens in a welfare state. The authors of the interdepartmental committee report seem to be saying two slightly different things. On the one hand, they state that mentally retarded people in institutions were included within a policy which met all their needs at no personal cost. Given the conditions under which mentally retarded people were kept in institutions, however, it was certainly ironic, if not clearly insulting to the idea of the welfare state to refer to cradle to the grave services in this context. On the other hand, the authors imply that the province would not extend such free, cradle to the grave services beyond the institution to the community. Although they admit that there was a low level of community services for mentally retarded people in Ontario at this time, they say without further elucidation: "It is not feasible for the Government to institute and operate comprehensive local services." Exactly why this was so is not clear from the report, but most likely three reasons were involved. First, the government did not want to commit itself to the potentially enormous investment that would be necessary to provide community services.[31] Second, the provincial government was reluctant to compel local governments to provide these services. For over a century from the very inception of mental health and mental retardation policy, the local governments had played practically no role at all in the provision of services. Even when they were forced by the provincial government

to establish houses of refuge and houses of industry after the turn of the century, they did so reluctantly. Since the Progressive Conservative government depended for a good deal of its support on the smaller towns and municipalities in Ontario, it was not likely to reverse a long-established tradition. This is why the committee recommended that local services be provided in the first instance by local associations for the mentally retarded rather than through legislation compelling municipalities to do so. But perhaps one should not be too critical of the government at that time, for even in Great Britain where in 1959 the Minister of Health stipulated that local authorities had to provide a full range of community services for mentally retarded people, including residential accommodation, a departmental report of 1971 noted that community services were "grossly deficient in quantity. . . . In particular there is a serious shortage of adult training centres, gross shortage of residential accommodation and great need for more trained staff of all kinds."[32] A third reason for government reluctance to provide a universalistic program of community care derived from ideology. Although the Progressive Conservatives had come to accept that the full responsibility of the state was engaged in the case of physical illness and education, they were not prepared to agree that the government's responsibility was fully engaged when it came to providing community services to mentally retarded people. At this point, the argument went, one was not talking about health policy, but social welfare policy, and in that case the government had much more limited responsibilities.

With regard to the large mental retardation institutions the interdepartmental committee quoted from a paper by Dr. B.W. Richards, a British psychiatrist who was then visiting professor of mental retardation at the University of Toronto (a chair financed by OAMR). Richards stated that Ontario would probably need an additional 3,000 to 4,000 beds by 1972 to keep up with the existing pressure on the large hospitals. He also stated that the ratio of beds to population in Canada was higher than in Great Britain and the U.S. because of the lack of community care facilities in Canada. But the committee remained agnostic as to whether these additional beds would be provided in "large or small provincial institutions or in nursing homes, in residential homes and other local facilities." Another problem the committee touched on concerned the fobbing-off process which was continuing even in the 1960's. "It appears that a substantial percentage of admissions of wards of the Children's Aid Society to the Hospital Schools are primarily for social reasons and become urgent because of the inadequacy of local facilities and/or financial support, or because of pressures from local government." Here too, since the very inception of lunacy policy in the 1840's one of the major underlying processes which led people to institutions was still at work. Quite clearly the committee was right, there was a process of selection through which only certain people travelled the route from the community to the large institutions. It was not mental retardation that was the sole deter-

mining factor, but rather mental retardation (however that may have been defined) plus a whole array of other factors including the nature of the family (single parent, emotionally unstable), the financial or economic status of the family or relatives of the person, or possibly no family as well as the state of local community services which, in the case of Ontario, were "at a minimum and consist for the most part of day school classes."[33]

Although the committee complained that it "lacked clear terms of reference" and that "some of its members did not feel free to debate issues on which their Departments had already established policy," they did conclude with ten recommendations. The principal recommendations were that the government "commit itself to the development of a unified policy . . . that a policy decision be made as to the extent to which local development will be substituted for the further development of centralized provincial services," and "that a temporary commission or study group be appointed to survey needs and present services." The committee also recommended its own dissolution. There were no recommendations on alleviating the various social, financial or political factors which led to so many people being sent to the big institutions.

The Roberts Report on Mental Health in Ontario

In February, 1963, six months before the interdepartmental committee reported to Dr. Dymond, one of the most critical reports on Ontario's mental health program was completed by Dr. C.A. Roberts, medical superintendent of the Verdun Protestant Hospital in Montreal.[34]

Dr. Roberts was especially critical of the fact that the Ontario Hospitals were under the direct control of the Department of Health through the Deputy Minister and the Chief of the Mental Health Branch. Although Dr. Roberts may not have been aware of it, there were some striking similarities between his views on the Ontario Hospital system and those put forward in 1937 by the Mental Hospital Survey Committee. Once again the same arguments about the overly paternalistic attitude of the Department of Health bureaucracy were trotted out, and once again, there were criticisms of vague or divided lines of authority leading to low staff morale and an unwillingness to take initiative at the local level.[35] Roberts noted that there seemed to be a lack of coordination between the actual needs of the mental health branch of the Department of Health, and the program of hospital construction carried out by the Department of Public Works:

> In the selection of sites for new hospitals it would appear that the presently accepted principles governing the provision of psychiatric treatment services are not being followed. The location of the hospitals and the number of beds being provided in each are not related to the needs of the population to be served. The present large scale renovation and building program in Ontario Hospitals does not seem

> to be based on a set of principles clearly stated and clearly understood by those responsible for construction and those responsible for the provision of patient care. It is also apparent that the Ontario service and the Public Works Department either have no philosophy about hospital construction, or that they reject many presently held principles about hospital construction without enunciating their reasons for doing so.[36]

Roberts observed that hospitals were still being constructed with nursing units of over fifty beds, at a time when it was generally agreed that such units were much too large, while there was a "marked shortage of space for day and recreational activities. It has been impossible to determine the basis on which decisions are made regarding capital expenditures. Facilities badly needed in one area are missing, whereas in other areas facilities are being constructed which are quite unnecessary."

Although Roberts refused to speculate about this rather peculiar situation, this still does not prevent us from making some educated guesses. For a long time the government of Ontario had been accused of establishing mental hospitals and mental retardation facilities in areas which were either of the same political coloration as the governing party, or to shore up or raise the economic status of a region. In reading the debates of the Ontario legislature one will frequently find MPPs complaining about the need for an Ontario Hospital in their region, or about broken government promises to build them. Whatever the reason for the design and location of the Ontario Hospitals over the years, the fact is that the decisions were taken by the Department of Health and the Department of Public Works. Local communities, and especially voluntary agencies (such as they were) were excluded from the process of decision making. In these circumstances political considerations carried a great deal of weight, while the needs of mentally ill or mentally retarded people played a secondary role. Despite criticism, decisions about the location of mental retardation facilities continued to be made on what were at the very least, highly questionable grounds. Even during the late 1960's and early 1970's for example, the Department of Health, and later the Ministry of Community and Social Services continued to look for disused federal army or radar bases, or for buildings put up for sale by religious institutions as suitable accommodation for mentally retarded people. Frequently these buildings were located in rural areas, far from population centres or were not served by any reliable form of public transport. The main object in such a policy was to get the best site at the cheapest cost and to provide employment in the area.

In 1963, however, Roberts proposed that one way to solve the problem of bureaucratic and political motives taking precedence over the needs of the people involved was to remove the Ontario Hospital system from the "direct responsibility for the construction, reconstruction, maintenance and operation of these hospitals" and to put them under "indepen-

dent, legally constituted Boards" similar to those which administered the public general hospitals. This recommendation was ignored.

In his report Roberts also added his voice to the growing chorus asking for increased local and community facilities for mentally ill and mentally retarded persons:

> As it is now widely recognized that continuity of care at the local level is a sound principle on which to base the development of medical services, it would seem appropriate to organize the mental health services in a manner which would promote such continuity. Continuity of care implies the integration and co-ordination of services at the local level, and acceptance of this principle implies that future treatment services should all be comprehensive in nature. . . . Thus a general hospital or a mental hospital should provide a full continuum of care and all psychiatric services should be seen as community services.[37]

As regards mental retardation policy Roberts criticized the "absence of adequate community facilities" including sheltered workshops, and recommended that services be provided at the local level. According to Roberts, "small special residential training schools should be developed in each local area."[38] The large institutions would fulfill a role mainly with regard to severely retarded people, although even here Roberts thought it might be "desirable in due course to provide for the continuing care of the most severely mentally retarded in local communities." And he concluded: "Implied in all of this is the development of supporting agencies . . . to enable each community to have a comprehensive program for the care of the retarded"[39]

Included in the Roberts' report is a brief from the committee on mental retardation of the mental health branch of the Department of Health.[40] Although much of what the brief has to say about mental retardation agrees with Roberts there is an important difference in tone and emphasis. For example, the brief on mental retardation is careful to limit the provincial government's role to one of "assisting" or "establishing liaison" with the community in order to establish community facilities and services. And among the various "principles" that are to be considered in mental retardation policy is that "programs must be directed to maintain the integrity of the family."

The central importance of preserving the family is emphasized time and again in government statements on mental retardation policy. In 1979, for example, this principle was restated by Minister of Community and Social Services Keith Norton when he said: "Our objectives and service initiatives emphasize services which permit families to regain a measure of self reliance. . . . The basic thrust of our planning encourages the development of services which enable individuals and families to help themselves."[41] But how relevant is this principle to mental retarda-

tion policy, and what does it mean? In its brief to C.A. Roberts in 1963, the committee on mental retardation listed some of the reasons why children were admitted to institutions. They were: "lack of community facilities, lack of community supervision, broken homes and unaccepting families." Given the fact that many mentally retarded people have no home to return to, or have become enmeshed in the social welfare net because of an irrevocable family breakdown, in these circumstances the family would seem to have no role to play. However, one can guess at two different meanings to be derived from the term. At one level it means exactly what it says: the government is expressing some intention to help families care for their mentally retarded children or relatives. Whether in actual fact the government has followed through on this is another question. But at another level the emphasis on preserving the family is a reminder of the limited role the government expects to play in developing community facilities and services for mentally retarded people. One does not find the government justifying public education or health care in terms of preserving the family, although it is arguable that that is one positive effect of these policies. Thus the term "family" becomes a metaphor for the welfare-oriented nature of mental retardation policy, for a limited government role, and for the expectation that families or voluntary organizations will contribute to the cost of programs for retarded people.

As regards institutions, the mental retardation committee said little about the means whereby local residential facilities or services were to be provided, but it did recommend the establishment of four additional hospital schools for the mentally retarded persons. None were to be larger than 600 beds. In the "future" the committee also proposed that small regional units with a capacity of 100 beds each be established in the various counties. Finally, it suggested that mentally retarded children under the age of 18 be allowed to qualify for a disability pension without a means test. None of these proposals was ever acted upon.

Perhaps the most interesting part of the Roberts' report concerns an issue that was an important indication of how the government was going to proceed in scaling down existing institutions and returning mentally ill and mentally retarded people to the community. In 1959, Roberts pointed out, the Minister of Health announced a policy whereby a certain number of aged patients in mental institutions would be "removed from the hospital, as such, and placed in a wing or cottages of the present structures for the time being, where they will be cared for in pleasant and comfortable surroundings. The ultimate objective is that they will be separated completely from the hospital setting and placed in a special type of institution where they will live in a homelike atmosphere and be given the care necessary for them, but will not occupy the time of highly trained specialists." In 1961 these patients were formally discharged from the mental hospital and placed in so-called Rehabilitation Units within the hospital. Nine hundred and fifty one mental hospital beds were reclas-

sified in 1961, and 2,781 additional beds in 1962.

As Roberts notes, the government wished to create the impression that although they were no longer amenable to active treatment in the mental hospital (most of them were in their sixties, and long term residents of the hospital) these patients were ready for transfer to nursing homes or to chronic care facilities. But the mental health branch later agreed that some of these patients could be kept in locked wards in the residential units. Despite the rhetoric, therefore, some patients were by no means ready for transfer to the community. According to Roberts: "In discussion with those responsible for the administration of the program it becomes apparent that no common philosophy has yet developed and that these units are being developed more as a result of administrative pressures than in terms of meeting the needs of the patients."[42]

There were two sorts of pressures this policy was designed to meet: financial and administrative. Because cost sharing funds were then available from the federal government for chronic care patients, the Ontario government hoped that it might obtain access to those funds by creating what were ostensibly chronic care wards within the mental hospitals. In any event, the strategy failed, and federal monies were not forthcoming. In addition, by discharging a certain number of patients from the mental hospital, and declaring them residents in the residential units (which were located in the same hospital and which, according to Roberts, could barely be distinguished from the rest of the hospital) the former patients were no longer covered by hospital insurance and were charged between $7.00 to $10.50 per week for maintenance costs. At that point relatives could choose to take the patient home, transfer them to a private institution, or agree to their remaining in the residential unit. Since the patients would not have been in the mental hospital in the first place if relatives had been willing to keep them at home or bear the cost of private care no real choice was being offered.[43]

This policy of creating different models of care and administration for patients depending on whether or not they were amenable to further active treatment was nothing more than a twentieth century version of the century old practice of separating the "curable" and "incurable" insane. When asylum superintendents debated this policy in the 1860's it was argued that those labelled as incurably insane would be stigmatized in such a fashion as to discourage any attempts at further treatment, that they would wind up in second-rate institutions, and be neglected from that point on. Despite these objections it has been quite typical to distinguish among patients in this fashion.

In fact, two treatment policies already existed in Ontario mental hospitals at the time Roberts submitted his report. "In actual fact when visiting selected hospitals it was impossible to identify the difference between those wards classified as residential and those classed as hospital. Generally speaking, these hospitals have the very highest concentration of staff on the acute admission, convalescent wards and on the infirmary or medi-

cal and surgical wards, and as this concentration of staff has always existed and as there has been a minimum of staff on all of the long-term wards, it has not been possible to make any difference in the staffing of residential units as compared with other long-term units."[44] Moreover, the province could now subtract patients transferred from the hospital to the residential units from the total number of mental patients in the province. Although the mental hospital population was declining for other reasons, the creation of the residential units helped diminish the number of people formally listed as patients. Finally, the creation of the residential units—and the subsequent legislation concerning the Homes for Special Care—allowed the province to claim that in keeping with the contemporary trends in mental health policy it was moving toward a system of community care for mentally ill persons.

The reason why this policy is of relevance to mental retardation policy is that, as in the past, developments in mental health policy in Ontario frequently indicate the future direction of mental retardation policy. A few years later it became apparent that the government was going to justify the transfer of large numbers of mentally retarded people into the Homes for Special Care program as a step in the direction of community care. Once again, it is arguable that this move was done as much for financial and administrative reasons, as for the benefit of mentally retarded people themselves.

During this period the role of the doctor had begun to change, and the influence of the medical profession on mental retardation policy to decline. Except for J.P. Downey who was superintendent of Orillia from 1910 to 1925, the superintendents of Orillia as well as those of the various insane asylums were all medical doctors from the middle of the nineteenth century to the 1950's. By the postwar period, however, serious changes had taken place in the medical profession in the way it conceptualized the practice of medicine, and in the image of the doctor.

At the end of the nineteenth century the doctor was described in terms of his high moral character and discerning judgment, as a person whose experience with human failings and weaknesses bestowed on him the kind of wisdom inaccessible to other professionals. It was not access to an arcane body of technical skills or a particular expertise that gave the medical profession its status, but rather the force of character that was assumed to derive from the educational and practical experience of medicine. Thus, medical doctors had a diffuse kind of authority which allowed them to speak and be heeded by others on any topic from immigration policy to public health, mental illness, mental retardation, unemployment, illegitimacy, etc. As Michel Foucault puts it: "It is not as a scientist that *homo medicus* has authority in the asylum but as a wise man. If the medical profession is required, it is as a juridical and moral guarantee, not in the name of science."[45] But with the rise of other professionals equally or perhaps even better equipped than doctors to speak of such disparate social and health matters, the authority of the medical

profession began to narrow. Moreover, with the rising success and prestige of science, and with the acquisition of scientific skills, techniques and vocabulary by doctors, it became apparent that the continued authority and prestige of medicine depended on the degree to which it could convince the public that it was grounded in the canons of science.

For the general public, science is conceptualized as an endeavour where problems are solved on the basis of generally accepted theories and practices. As the problem-solving capabilities of science have increased enormously over the past century, its prestige and power have also increased. With the increasing effectiveness of drugs, and of high technology devices in medicine, the medical profession necessarily began to share in this prestige. Moreover, the profession gradually elaborated a paradigm wherein the patient became the living embodiment of a series of problems to be solved through the application of highly effective scientific techniques. Medicine became less of an art and more of a science.[46]

As the effectiveness of medicine came to be judged in terms of its success rate (and its prestige to derive from the use of expensive and awe-inspiring machinery) it became increasingly pointless for the medical profession to devote its attention to those handicapped, incurably or chronically ill, senile old, mentally retarded or mentally ill people who were not amenable to cure, and could not be scientifically treated. Moreover, since the prestige of the doctor no longer derived from his "humanitarianism," from his ability to establish a highly personal and deferential relationship with his patients, but rather from his skillful application of scientific techniques, the fields of mental illness and mental retardation were gradually abandoned to professional administrators or to psychologists and psychiatrists. This helped make it possible for social workers, government bureaucrats, academics and others to argue for a major re-orientation of mental health and mental retardation policy.

9

Toward Deinstitutionalization

During the 1960's in North America mental retardation was one of the most frequently discussed issues in social policy. One of the major reasons was because John F. Kennedy, President of the United States from 1960 to 1963 had taken a major interest in the field. In October, 1961 Kennedy appointed a panel of leading professionals to make recommendations to the federal government on all aspects of mental retardation policy. On October 16, 1962 the President's Panel on Mental Retardation called for increased expenditures on research and better educational and training facilities; recommended that each state should establish interdepartmental committees for better planning and coordination of state services for mentally retarded persons; that within state departments already concerned with mental retardation a special division or bureau should be established to administer services to mentally retarded people, or that a special consultant with department-wide powers should be appointed; and that professional and citizen advisory groups should be appointed to advise the U.S. federal Department of Health, Education and Welfare on mental retardation policy.

Within Ontario, however, the members of the OARC Institutions Committee had become increasingly angry with and frustrated by the government's reluctance to make any major policy changes. One of them recalls:

> We were pretty fed up with things in the hospital schools because it was all piecemeal. If you put some pressure on you'd get some weather stripping put in. You'd ask them about a particular problem and the superintendents would say "We can't get anything done but if you [the OARC] would raise a little hell that would help". . . .

> So finally we got fed up and we wrote a blistering brief and we went to see Dymond. And in effect, we told Dymond that the problem was that he didn't have any real policy on mental retardation, that he just left his superintendents out there fighting the battle of numbers and trying to cope while people kept shipping more kids out to them and they didn't know what the hell to do. . . . He kept his cool for a while and then he blew his top at us. "Well, you say we don't have any policy, but I do think I have a policy" and he said, "I want you to go out and sit down with [my senior people] and I don't want you to leave until you work out a policy for us on institutions for the retarded." So we thanked him very much and went out. . . . I remember they sent out for sandwiches and we sat down. The white paper subsequently came out of that . . . and they set up this interdepartmental committee.[1]

The result of this meeting between the Minister and the OARC delegation was the formation of a study group on mental retardation consisting of some of the members from the now defunct interdepartmental committee, but with the addition of W.R. Kirk, Executive Director of the OARC and Dr. Donald Zarfas as chairman. The formation of this committee was extremely important since it allowed the OARC to participate in policy formulation within government itself. Until 1963, OARC members had been present at occasional meetings of institution superintendents, but these usually concerned details of policy rather than policy formulation. Moreover, the appointment of Dr. Zarfas, first as consultant, and then as Director of the Mental Retardation Services Branch in the Mental Health Division of the Ministry in July 1965, gave explicit recognition to the OARC's desire to have someone in government directly responsible for mental retardation policy in the Ministry of Health. The creation of the Mental Retardation Services Branch thus provided a structural source of both policy analysis and formulation, as well as a target for criticism.

By 1964 the Canadian government had also become interested in the problem and a federal-provincial conference on mental retardation was called for that October. In order to prepare for the conference, Dymond asked the members of his newly appointed study group to write an Ontario position paper. Their paper, "A Spectrum of Mental Retardation Services in Ontario," and their "Conclusions and Recommendations for Mental Retardation in Ontario," provide some interesting insights into contemporary ideas on policy and the future direction it was expected to take.[2]

Both papers emphasize the necessity for the province to move away from an institutional-custodial model to a community-based model. Both papers also stress the role of government in assisting local associations, voluntary groups and local governments to provide community services. However, the authors did not suggest that the provincial government as-

sume full responsibility for a community program. As the authors of the "Conclusions" put it, "the particular duty of government should be to provide, directly or indirectly, a wide variety of specialist and supportive facilities to augment individual, family and community resources. Its major role is to assist in providing the mentally retarded and other socially handicapped individuals with an environment as rich and satisfying as that enjoyed by the rest of the community to which they belong. In doing so the government should be careful not to usurp the responsibilities of parent, families and community agencies." Later the report speaks of "shared rather than total responsibility," and of the commitment to shared responsibility as being a "unilateral shift in emphasis" from the previous "total responsibility." What the authors mean here is that whereas in the past the province had provided 100 percent funding for mental retardation institutions, it would not do so in the case of community facilities and services. Specifically, local associations of the OARC would be expected to play a major role in administration and funding.

In a paper submitted to Dymond after the 1964 federal-provincial conference, the coordinating committee reaffirmed the notion that community services for mentally retarded persons should be improved and extended. It asked that capital and maintenance grants to local associations be increased to 80 percent for community residences; that financial assistance to retarded people in workshops be extended to include those who would probably not obtain remunerative employment, rather than helping only those who moved on to other jobs; that the Day Nursery Act be used to encourage pre-school programs for retarded children, that financial assistance be made available to parents for the home care of severely retarded or multiply-handicapped children, and that some form of personal guardianship for retarded people be established.[3] As regards education, the committee recommended that: "All retarded children would be eligible to attend the schools within the regular school system and the school system should remain responsible for the education of all mentally retarded children so long as they may profit from education and training." Finally, it recommended that a committee of deputy ministers from various departments be established to integrate policy, that an advisory committee consisting of civil servants and representatives from the OARC be established to provide access to policy formulation, and that a mental retardation branch be created within the Department of Health.[4]

Here the committee was confronting the thorny problems that always arise in trying to formulate policies for specific client groups. Government ministries are typically organized along functional or service-providing lines: they deal with health, welfare, the environment, social security, foreign affairs, etc. Rarely are they organized to provide services to a specific group of people. But mental retardation is more than just a question of low IQ. It has long been recognized that the vast majority of people with IQs low enough to be categorized as mentally retarded never come to the attention of government. On the other hand, many

people who are not retarded but poor, physically ill, senile, mentally ill, delinquent, deaf, blind, orphans or from broken homes have been labelled and treated as retarded. Often, too, retarded people suffer from a variety of social and physical handicaps. Thus, authorities have to decide what categories to put people into, whether to label them as mentally retarded, or to pin some other label on them. Should a mentally retarded child who is emotionally disturbed be labelled as retarded, or as mentally ill? Should a senile woman who is mildly retarded be looked after by the mental retardation service or by the department that deals with the elderly? Frequently people with multiple handicaps fall under the jurisdiction of a number of government agencies. This leads to problems in coordination and accountability, which in turn leads to demands for the formation of interdepartmental or interagency committees to resolve the ensuing problems. Thus, as mental retardation policy became an increasing concern in the 1960's, governments in North America began to establish interdepartmental committees to deal with mental retardation.

The OARC was particularly well disposed toward the recommendation of Dymond's coordinating committee for not only did they believe that an interdepartmental committee was necessary to coordinate policy, but they were attracted by the prospect of obtaining direct access to government through the establishment of a specific division responsible for mental retardation policy in the Department of Health. Moreover, they believed that the establishment of a separate division would also have a positive effect on public opinion since it would constitute a clear recognition by government that mental retardation policy was distinct from health or mental health policies.

Dymond's coordinating committee also recommended that "at this time no additional hospital school facilities be developed, but that this branch [Health] support the Department of Public Welfare in the establishment of community facilities throughout Ontario." Another major suggestion was for a reorganization of the internal structure of the various mental retardation facilities around a unit system. This was an attempt to get away from the monolithic "medical-nursing" orientation and to move toward a "living-learning" model.[5] Although this system had already been introduced elsewhere in North America, this was its first appearance in mental retardation institutions in Ontario. It was a laudable attempt to decentralize within the institution by creating separate units: a medical-nursing unit, an activity unit for the seriously handicapped, an educational unit and an adult rehabilitation unit. But its creator, Dr. Zarfas, met with staff resistance, and at Orillia, the problem of integrating the semi-autonomous units with programs that crossed unit lines was one source of the troubles that ultimately led to a provincial inquiry in November, 1976.[6]

On June 7, 1965 Dymond presented the results of the federal-provincial conference and of his advisory group's recommendations to the legislature. Describing it as a "Blueprint" Dymond began by noting that

"mental retardation is much more than a health problem . . . successful treatment involves specialized education and welfare programs. All future programs will be based on this partnership. The government has accepted, in their entirety, the recommendations of this group, and these proposals will now form the basis of mental retardation planning for this province for the next several years."[7]

Although his advisory group had explicitly recommended that no new large institutions be built, Dymond omitted any mention of this in his speech. Ten days later, however, he said: "I do not think we should encourage the establishment of a great many hospital schools. After all, with the increased number of community schools for the retarded, the existing residences will fill about the last remaining gap."[8] By contrast, in January, just six months before Dymond's "Blueprint" speech, Governor Rockefeller announced that seven new state schools with 1,000 beds each were to be established, four of them in the New York City area, and three in upstate New York. The New York State Association for Retarded Children supported this program, since it was thought to be "better than 3,000-bed warehouses, though not as good as California's new plan for 500-bed facilities."[9]

One reason for Dymond's willingness to look for alternatives to constructing large hospitals may have been the fact that in 1965 the federal government announced that funds would no longer be made available for hospital construction to the province. In addition, Dr. Barry W. Richards, the visiting professor from England, had been quoted in the legislature as saying that: "Ontario seems to have a bed complex. Certainly Ontario has more institutional beds for retarded children per 100,000 population than either Britain or the U.S. and the waiting lists are long."[10] But there is no doubt that after his experience with the dramatic decline in tuberculosis obviating the need for additional sanitoria, and the continuing decline in the number of patients in the mental hospitals (many of them, however, having been merely transferred to residential units), Dymond was reluctant to commit the government to building additional large mental retardation institutions.

Another change, not mentioned in the blueprint but one made shortly after, was the establishment of a "priority rating scale" for admission to mental retardation institutions. Designed to avoid the resort to political pressure used by people desperate to gain entry for their children or relatives to the institution, the scale was supposed to measure a person's need for placement and then rank him on an admission list. Dymond also ensured that modern management techniques would be used in the day-to-day administration of the institutions. One Ontario civil servant said that before 1965 "the hospital system was 100 years behind the time. They were poorly administered with no account taken of cost per patient or costs of items such as soap or laundry. This was handled by the Bursar who usually had made his way up the hierarchy from clerk but who had no training in management."[11]

The creation of the Mental Retardation Services Branch in Health and the appointment of Dr. Donald Zarfas as its Director also had an important effect on the evolution of policy. This development legitimized the notion that mental retardation policy was different from mental health policy, provided a structure to coordinate what had previously been a series of disparate policies toward mentally retarded persons as well as creating a focal point for the OAMR which could now direct its efforts toward a specific structure and a specific individual. In addition, Dr. Zarfas had an excellent reputation in the field and he enjoyed very good relations with the OAMR.

However, the creation of an interdepartmental committee was only temporarily successful. Theoretically, through the presence of its executive director on the committee, the OAMR could participate directly in the process of policy formulation at the deputy minister level. But the committee was increasingly unable to reach agreement on policy among the various departments represented and it eventually became ineffective. Ironically the reasons why such committees are usually ineffective had already been discussed at the 1964 federal-provincial conference:

> In Canada, for some years we have noted the formation of an interdepartmental committee in several provinces, usually composed of representatives of the departments of health, social welfare, education and labour. However, it appears that this pattern has not produced all the desired results; one reason may be the fact that this committee's role is not clearly defined and that it is responsible to several departments, which often means responsible to no one at all. This type of interdepartmental committee, acting mostly in an advisory capacity, transmits its "coordinated" opinion to each department involved, but it has little integrating influence regarding the development of services.[12]

The policies that Dymond announced in his Blueprint speech were not particularly new. Almost all of them had been mentioned in the report of the Royal Commission on Health Services in 1964. In line with contemporary thinking on mental health and mental retardation, the Royal Commission had suggested that "the majority of mentally retarded children, i.e., mildly retarded children, not be segregated in institutions but remain at home, in the community, and be educated in special classes in the regular school programme," that communities provide sheltered workshops, and that only when necessary, mentally retarded children should be sent to "a small hospital unit of not more than 100 beds located in the same general area."[13]

On the question of rehabilitation of mentally retarded people, Dymond seems to have had mixed feelings. In 1966 he commented: "I think it is ridiculous to speak of rehabilitation in respect to the mentally retarded. They have never been rehabilitated and this is what we try to do in so

far as is possible.... I would be very loath to leave you or any member in this House under the impression that I am optimistic that many of these younger people can ever be returned to the community as self-supporting." On the other hand, and in complete contradiction to these remarks, just a few minutes later Dymond said that the industrial therapy programs in institutions were growing in number and that "the division of mental health and the department division of rehabilitation are very anxious and very actively seeking to promote this sort of thing and the time, I would suggest is not too far distant when our patients will be in competition with normal people in various lines of endeavour."[14]

Despite the fact Dymond was obviously sympathetic to the cause of mentally retarded persons, and despite the fact that a series of important legislative measures were passed during the late 1960's (for example, the Vocational Rehabilitation Act of 1966 and the Homes for Retarded Persons Act of 1966) the actual results were disappointing. By 1970, there were only eight community residences operating under the Homes for Retarded Persons Act, four were sponsored by local associations and four by other groups. The situation was somewhat better as regards sheltered workshops, for in 1970 there were 84 sheltered workshops with 2,200 trainees run by the various associations. But the capital grant was originally set at 25 percent of costs, and the operating grant at $25.00 per person per month. This meant that until government subsidies were increased in the 1970's, the local associations were spending most of their budget on sheltered workshops with little available for other activities.[15]

Given the rudimentary state of community services during this time, it is not surprising that there was only a gradual decline in the numbers of mentally retarded people in the provincial facilities, from 6,424 listed as "in hospital" in 1964, to 1970, when the number had declined to 5,357 [See Table 5]. It would be incorrect to conclude from this that Dr. Dymond had accomplished what no other Minister of Health had done, that is, reversed the century-long increase in the number of mentally retarded people in institutions. Rather, some of the decline must be attributed to the large numbers of mentally retarded people who were transferred from the Schedule I facilities (so-called becaused they were subsidied at 100 percent of their costs by the province, and fully administered by the government) into the Homes for Special Care program where they were no longer listed in the mental retardation statistics. For example, by March, 1970, 1,184 mentally retarded people had been transferred to the Homes for Special Care program. If this number were added to the 5,357 people listed as in hospital in 1970, the total would be 6,541, a slight increase over the 1968 total. Another factor to take into account is the continued increase in the number of admissions to the various mental retardation facilities during this time.

The Homes for Special Care Program

The Homes for Special Care program was an outgrowth of the approved home program which had begun in the 1930's under B.T. McGhie as an attempt to reduce the institution population and to reintegrate selected psychiatric and mentally retarded patients into the community. The approved homes were selected by the institution which paid their owners a per diem rate for the patients transferred to their care. The approved homes were frequently located near the institution, and were often run by staff or ex-staff members from the institution. This program never entirely disappeared, for in 1979, 196 residents from the various mental retardation facilities were still listed as living in approved homes.

In 1964, legislation was passed setting forth provincial standards and regulations whereby private nursing homes might care for residents released from psychiatric facilities, and after 1968, from mental retardation facilities. The Homes for Special Care were intended for those people who were no longer able to benefit from active treatment. While the approved homes were selected and funded by individual institutions, the Homes for Special Care were selected by the Ministry of Health and their private operators paid a per diem rate by the Ministry. Government spokesmen claimed the program was intended to remove people from overcrowded and understaffed surroundings and to provide care for them in a more "homelike" setting in the community. The reality was quite different.[16]

At the inception of the program in 1964, 4,600 patients were selected from the various psychiatric facilities (excluding mental retardation facilities) and divided into two groups: one, of physically infirm patients was intended for the nursing home program; the other of ambulatory patients was intended for the residential program. The first group transferred consisted of the physically infirm mainly because there were already beds available in private nursing homes. Most of these people were elderly, for example, 63 percent of the patients transferred from the Lakeshore Psychiatric Hospital to the HSC program in 1965 were over 65 years of age. Ostensibly, medical or physical reasons were the basis for choosing those patients to be transferred to the Homes for Special Care; in reality, quite extraneous factors seem to have influenced the selection process. There is some reason to believe that those patients who had neither friends or relatives to object to such a transfer were more likely to be chosen than others. One of the civil servants involved in the program wrote: "While we would have liked more time to notify relatives, consideration had to be given to the fact that a vacancy in the nursing home produces a considerable financial burden on the home itself, and so a balance between the relatives' notification and the nursing home's needs had to be reached."[17] This is a shocking admission for it implies that the right of the patient or of those responsible for him to be informed of the impending transfer, and to object, were secondary to the financial difficulties of the private nursing home operators.

But it has not been unusual to put bureaucratic imperatives above the interests of the patients in the Ontario mental health system. Some years before in his study of the residential unit system, C.A. Roberts had noted that the then Chief of the Mental Health Branch had suggested to his staff that it would "simplify matters" if the majority of patients who were to be transferred into the residential units had no relatives or friends.[18] It quickly became apparent, therefore, that transferring patients to the Homes for Special Care had little to do with providing a more homelike atmosphere, or returning patients to the community, and had a great deal to do with saving the government money. In 1965, for example, the per diem payment from the government to nursing home operators was set at $6.50, and to residential home operators at $3.00. In 1966, the average per diem rate for the various psychiatric facilities was above $8.00. In addition, whereas patients in psychiatric hospitals usually did not contribute to their maintenance expenses, despite regulations which imposed a nominal per diem rate, the government quickly ensured that those HSC patients who received payments from the Old Age Security or Old Age Assistance programs contributed to their maintenance.[19] And by 1968 when federal cost-sharing funds had become available through the Canada Assistance Plan, the Department of Health noted that: "Arrangements were made with the Department of Social and Family services to identify patients...who, by virtue of indigence, became eligible for assistance under the Federal-Provincial cost-sharing welfare arrangements. Over 3,000 patients have been identified." Thus, in 1968 almost 50 percent of the patients in the program were contributing to their maintenance from their welfare payments.[20]

Over the years there were continuing complaints that the homes were located mainly in rural areas, that even in urban areas they were isolated from the rest of the community, and that given the very low level of government support, it was financially impossible for the private operators to provide any kind of recreational, occupational or rehabilitative therapy. Minister of Health Thomas Wells implicitly admitted that the homes were providing little in the way of active treatment. "Let us realize that these are not treatment facilities," he said in 1970, "these are residential homes. These people have basically been discharged from the institution and moved into the home, presumably because they have no family, no one else who wishes to take them, and yet we feel that there is a chance for them to go back out into the community."[21]

Government spokesmen suggested that volunteers from the community might meet some of the need for active treatment. But the opposition was scathing in its criticism. Mac Makarchuk of the NDP claimed: "In most cases in most of these homes there is absolutely nothing else for them to do. They vegetate."[22] Moreover, whereas in 1967 there were thirty-five staff workers in the HSC program, by 1970, only twenty-nine staff members were available to inspect the 719 homes scattered throughout the province.

In 1973, F. Allodi and H.B. Kedward showed the decline in the

number of patients at the Queen Street Mental Health Centre (the old Provincial Lunatic Asylum) was "associated with the residential unit program of 1961, the homes for special care program of 1965 [the legislation was actually passed in 1964], the Mental Health Act of 1967 and the community psychiatric program of 1968." They speculated that the decline in numbers "suggests the possibility that many patients had merely been transferred from the hospital to the homes for special care."[23] Moreover, a 1976 analysis of the program stated flatly: "The fundamental logic...is in fact economic." The authors point out that despite legislation requiring the homes to implement programs of recreational, social and physical activity, "in practice it is often impossible to implement this section of the act." And they claimed that the Homes for Special Care "in fact inherit the mental hospital's earlier custodial role."[24] It was also found that from 1965 to 1976 only 5 percent of the 14,000 people transferred to the program had been returned to the community. Given the advanced age, and the condition of the residents this may not be surprising. But given the smokescreen of rhetoric with which the government tried to surround the program, and the almost complete absence of programming within the homes, it is not exaggerating to characterize them as the new back wards of the 1970's.

The Social versus the Economic Market

The English social policy theorist Richard Titmuss has distinguished between the "economic market" which is characterized by "exchange or bilateral transfer" and the "social market" characterized by "grant, or the gift of unilateral transfer."[25] Although Titmuss personally favoured increasing the scope of the social market since he hoped thereby to humanize and equalize social relations in the capitalist welfare state there is nothing which says that the social market is necessarily better than the economic market in meeting people's needs. Indeed, for centuries those mentally ill and mentally retarded people who could afford to enter the economic market received markedly better levels of care and treatment than those who were forced to rely on the social market.

In the economic market each additional expenditure of funds will, hypothetically, improve the return on investment, that is, the level of care and treatment. But one must first have sufficient funds to get the kind of care one wants. The mechanisms of the social market are far more complicated. In a pure social market where the transfer is absolutely unilateral, nothing the recipient of the services can do will alter the nature of that transfer, for it depends entirely on the desire or whim of the giver. In this case, as Georg Simmel has pointed out, the recipient is nothing more than an almsbox into which one deposits a contribution.[26] But cases of this kind are quite rare in the history of social policy for, despite the basically unilateral nature of the transfer, the recipient usually has some effect on the giver and on the nature and form of the transfer. When the giver is a democratically elected government, then the most obvious way

recipients in the social market can affect the transfer of goods and services is through voting, pressure group activity, or through the other modalities of democratic politics. However, when the recipient population is small, as in the case of mentally retarded people who, along with families, relatives, friends and spokesmen probably number no more than 150,000 people in Ontario, then other factors in the political equation must be favourable if they are to acheive their objectives. Since 1945, pressure group activity has proven to be one particularly effective method whereby mentally retarded people in the social market have been able to affect the transfer of funds and services. Thanks to the activities of the OAMR, and to a favourable climate toward mentally retarded children and toward public education in general, mentally retarded children of all ages were given increasing access to education during the 1950's and 1960's.

But the social market is usually the scene of a struggle between governments intent on restricting the size and scope of the transfer of funds and services, and clients equally intent on enlargement. The history of social policy in the west is marked by a series of victories by both sides, and by innumerable compromises, standoffs and truces. Over the years, for example, health care in Great Britain, and to a certain extent, in Canada has gradually shifted from the economic to the social market, while in the U.S. it is almost completely within the scope of the economic market. On the other hand, the takeover by the Ontario government of the various local association schools for mentally retarded children with under 50 IQ was a distinct victory for those who supported the social market concept of education. If we define social welfare as including policies as diverse as unemployment insurance, government pensions, disability payments, general welfare assistance, workman's compensation, etc., each is now partially administered and funded by government. Most are based on some kind of social insurance principle, that is, the monies are derived from contributions from individual workers rather than from general revenue. Moreover, most people have to supplement what they receive, if they can, by seeking additional coverage in the economic market since government coverage is usually insufficient to meet their needs.

When the question of providing community services and facilities for mentally retarded people arose in the 1960's, the government had to decide whether it would use the social market mechanism and provide 100 percent funding and support as was the case with the existing large institutions, or whether it would resort to the economic market where mentally retarded people, their families and local associations would be expected to share in funding and administration. The government chose the latter. Given the fact that it was a Progressive Conservative government that made the decision, and given the nature of the Ontario economic and social system, there were good reasons for doing so.

No government willingly agrees to fully fund social services when the eventual costs are unknown. Since community services and facilities for

mentally retarded persons were in a rudimentary state in the 1960's, the government would have risked committing itself to enormous investments in the future if the community program grew unexpectedly. In fact, in 1969 total expenditure under the Homes for Retarded Children Act (1966) was $373,000. By 1980, expenditure for all community services for adults and children (excluding schools) had grown to approximately $70,000,000. Moreover, in the 1960's, the Ontario government already had before it the example of the surprisingly large demand for government support for the education of retarded children. Here, too, there was an enormous growth in expenditures from $550,000 in 1959 to $4,330,000 in 1969. However, one must be careful, since total provincial expenditures as well as expenditures for health policy grew enormously during this period as well. In fact, the actual expenditure on mental retardation as a percentage of gross provincial expenditure declined in the decade from 1960 to 1970 [See Table 3]. But it is unlikely the provincial policy-makers were thinking in terms of percentages, and more likely they were looking ahead to the actual dollar amounts they would be expected to provide in establishing community services.

Not only did the OAMR want local boards to operate residences but another reason the government asked local associations to contribute to the funding of community services related to the question of administrative responsibility. For years the government had weathered opposition criticism directed against the big mental retardation and mental health facilities. With local associations contributing to the funding of community services they would naturally be asked to help in administration. Thus they would have to bear some of the criticism that might be directed against community services. Finally, there was the question of precedent. If the government had immediately agreed to 100 percent funding of community residences and sheltered workshops, would not other groups among the handicapped population demand equal treatment? This precedent might have been used by non-handicapped groups, such as battered wives, homeless families, the elderly, or ex-prisoners to support claims for government assistance.

Another question the government had to answer during the 1960's concerned the model of care to be followed in dealing with mentally retarded people. Although Dr. Dymond seemed to agree with those who argued that massive institutions were unsuitable for mentally retarded people, along with most people at that time he thought mainly in terms of scaling down their size rather than in terms of a radical re-orientation of policy in the direction of community care. But the large institution no longer seemed to be fulfilling any useful function. The educational function in mental retardation policy had been assumed by the public education system. The social control function had almost vanished along with the myth of the menace of the feeble-minded although one could still find people in the mental retardation facilities who were there because no other agency or service could cope with them.[27] Mentally retarded people who

could survive in the community were now eligible for welfare funds through the Family Benefits Act, thus cutting into the social welfare function traditionally associated with the large institution. The only remaining function for the large institution appeared to be to serve its ancient role as asylum for those mentally retarded people who could not function in the community because of severe emotional or physical handicap or because they were rejected by family and community.

In addition, by the 1960's critics such as the American sociologist Erving Goffman, and Wolf Wolfensberger had begun to convincingly argue that by their very nature big institutions were impersonal, often unsafe, dehumanizing and irrelevant to the needs of mentally ill and mentally retarded people.

What were the alternatives? Dr. Dymond and many people in the Ministry of Health seemed to lean toward the idea of scaled-down institutions, and some increase in community services and facilities. But the implications of a move toward community care were not spelled out, although it seems to have been interpreted mainly as one means of reducing governmental administrative and funding responsibility, and of getting community organizations to take up the slack. This seems to have been the way Premier Robarts was thinking in a letter of February 12, 1965 when he noted: "It is the belief that the mentally disordered have, for a long time been looked upon as solely and entirely a Government responsibility and the Department of Health does not agree with that thinking. Dr. Dymond himself subscribes fully to the modern concept which looks upon mental disorder as a community responsibility in which Government participates."[28]

For years, however, Royal Commissions, investigating committees and special investigators had recommended a drastic increase in the provision of local services for mentally ill and mentally retarded persons. As always, the obstacle was government reluctance to fund a new and potentially costly program, the unwillingness of municipalities to spend their tax dollars on community services, resistance from communities to the presence of discharged mental patients or mentally retarded people, general public indifference to the plight of mentally retarded people in institutions and to a re-orientation of policy in the direction of increased community services, and, extremely important, the lack of any conceptual framework or coherent statement relating to the future of mental retardation policy.

Despite the passage of legislation such as the Homes for Retarded Persons Act of 1966, and a continued rise in the funding for sheltered workshops, the government had yet to present any scheme for reducing the size of the big institutions, or to demonstrate a real commitment to building community residences and improving community services. By the 1970's, however, all that was to change, and for the first time since 1945, mental retardation policy was to undergo a process of profound change.

10

From the Institution to the Community

The decade from 1970 to 1980 saw a major re-orientation of mental retardation policy away from emphasis on large institutions and custodial care and toward smaller institutions, group homes and improved community services. There were four main reasons for this change: the publication of a critical report, *Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario* by Walter B. Williston, generally known as the Williston Report; the development of a new conceptual scheme and a new vocabulary for mental retardation policy best summed up the in term "normalization;" the establishment of policy ministries in the Ontario government; and the acquisition by the province of Canada Assistance Plan (CAP) cost-sharing funds which could be applied towards mental retardation policy.[1]

The Williston Report

As is often the case in the history of social policy, the main catalyst of change was a scandal. On February 18, 1971, Jean-Marie Martel, a twenty-four year old ex-resident of the Smiths Falls mental retardation institution was found walking along a country road in bitterly cold weather. Taken to hospital, his condition was diagnosed as gangrene on the tips of the fingers of his right hand and on the index, middle and ring fingers of his left hand. About two weeks later, Frederick Elijah Sanderson, a resident of the same institution who had been released to do farm work in Richmond was found hanging by his neck in a hayloft at the farm. The coroner's jury returned a verdict of suicide.

The Ottawa newspapers gave full coverage to both incidents and as a result, on June 8, 1971 Ontario Minister of Health A.B.R. Lawrence,

appointed Walter Williston, a well-known Toronto lawyer, to investigate the incidents and make recommendations for reform. Williston and his associate Paul Green visited all the large mental retardation facilities in Ontario as well as a number of community residences, Homes for Special Care, approved homes and sheltered workshops. They heard oral presentations from the OAMR, the Canadian Association for the Mentally Retarded as well as a number of local associations, read some of the major studies in the field and consulted with prominent authorities. A little more than three months after his appointment, Williston's report was released by the Department of Health. The Williston Report ranged far and wide over the entire field of mental retardation policy. Above all, it was a scathing indictment of the large institutions. The very first sentence of the section on "Suggestions" says: "I recommend that the large hospital institutions for the mentally retarded be phased down as quickly as is feasible." Then there follows a sixteen-point indictment of the big institution.

> Living conditions tend to be dull, monotonous and impersonal. The wards are severely overcrowded.... Any degree of personal attention or privacy is simply not possible...I have found that many of the wards are unnecessarily locked.... Contacts between the mentally retarded person and his family are weakened and often lost altogether...such institutions are isolated from the rest of the community.... There is always an insufficient number of physicians; psychiatrists, dentists, psychologists; occupational, physical and speech therapists; nurses; social workers and other skilled professional available.... The buildings...constitute a serious fire hazard.... These institutions are not an economical way of providing for custodial care...they are usually too remote from universities or other centres of higher learning.... The mentally retarded person on returning to his community is beset by the additional problem of being stigmatized as a former resident of an Ontario Hospital School.... Such an institution forces the retarded person to function far below his development possibilities.... The residents are paid minimal and completely unrealistic wages for their work — from 4¢ to 8¢ an hour.... The Ontario Hospital School system is divorced from the mainstream of health, education and social and family services.... Lastly I suggest that a century of failure and inhumanity in the large multi-purpose residential hospitals for the retarded should, in itself, be enough to warn of the inherent weakness in the system and inspire us to look for some better solution.[2]

Despite these strictures Williston cautioned against the immediate and complete abolition of the large institution since, he noted, retarded people released from them still lacked the necessary community support services. Rather, he suggested that the big institutions be gradually reduced to 40 percent of their capacity, at which point they might play a

role in providing nursing care for severely retarded persons, custodial care for those with severe behavioural problems, as crisis intervention or short-term parent relief centres, and as training and research centres.

For Williston the alternative was clear. "Every mentally retarded child should be with his own family until he reaches adulthood unless he imposes a undue burden on them." Adults should have access to community-based residences located in population centres and as close as possible to their homes. They should "be as similar as possible to a typical house or apartment so that the residents will be educationally furnished with life conditions similar to the ones they will meet in other parts of the community. . . ." Moreover, Williston suggested that mentally retarded people should be able to draw on the generic educational, recreational, commercial and professional resources of the community in the same fashion as any other citizen.

As regards support services, Williston recommended an array of home visiting and counselling services, day nurseries and day care centres, the provision of short-term crisis relief programs in residential settings, homemaker and babysitting services, foster grandparents (a program used in the U.S.) and guardianship services. He suggested that retarded children under the age of eighteen be eligible to receive the $105.00 per month then available only to mentally retarded adults as disability payments. Although Williston heads one section in Part III "Reasons for Abolition of the Means Test," he never explicitly identified which means test he was talking about. However, he proposed that the community provide all the services necessary to help parents bring up their handicapped children. "I suggest that we must all soon spell the death knell to our poor law legacy as applied to handicapped persons and to the social attitudes and practices which stem from them."[3] The clear implication is that mentally retarded people and their families should receive the necessary services not on an income-tested basis but rather as a matter of social justice.

In his discussion of government planning and organization of mental retardation policy Williston was critical of the dispersion of responsibility across numerous departments and branches as having a "deleterious effect on policy. . . . In Ontario, no one person or department has the responsibility for overall planning for the handicapped or even for the mentally retarded. There is no overall planning and there is no centralized budgeting." The result was that each department tended to focus on its own objectives and to ignore the overall needs of those they were supposed to serve. "The ill-defined and ambiguous boundaries generate friction between departments and their staffs . . . the lack of unity in command results in a fragmental delivery of services in the community. . . . The structuring of governmental patterns for the delivery of services is vertical when it should be horizontal."[4] Although the appointment of an interdepartmental committee had somewhat alleviated the problem, it was hampered because it had no independent authority of its own and because each member was in effect the delegate of his own department.

Nor did the committee have any budgetary authority. To remedy this, Williston recommended the establishment of "one department responsible for services to all handicapped persons and their families." A minister with "cabinet authority" would take over the "planning, coordination and centralized budgeting" of policy although the actual implementation of policy would continue to reside in the traditional departments.

Williston did not inquire too deeply into other areas of mental retardation policy such as the Homes for Special Care program or conditions in the mental retardation units in psychiatric hospitals. In the case of the Homes for Special Care he merely noted that the residents should be provided with a comfort allowance and although he was critical of the level of staffing and the overcrowding in the mental retardation units of the psychiatric hospitals, he made no specific recommendations regarding them.

The Williston Report met with immediate acclaim, especially from the OAMR and from groups interested in mental retardation policy. Some civil servants at Queen's Park claim that Williston was overwhelmed by officials from the OAMR and that his views were an uncritical reflection of the OAMR's ideas on policy. Certainly Williston seems to have developed close personal relations with Angus Robertson, the President of the OAMR and with some of the top Department of Health civil servants such as Dr. Donald Zarfas of the Mental Retardation Services Branch.[5] But there is also little doubt that Williston was deeply impressed by what he saw in his travels around the province, and that his report was an accurate reflection of his personal feelings on the matter.[6]

In any event, the Williston Report was the first, and probably one of the most important influences on the evolution of mental retardation policy in Ontario during the 1970's.

Normalization

In addition to the dramatic impact of the Williston Report, equally important changes had been taking place at this time regarding the vocabulary and conceptual framework of mental retardation policy. Perhaps the best-known term to enter the vocabulary was "normalization."* It had been used first in 1959 by the head of the Danish mental retardation service, N.E. Bank-Mikkelsen who defined it as "letting the mentally retarded obtain an existence as close to the normal as possible."[7] In 1969, the term was further defined by Bengt Nirje (who was then executive director of the Swedish Association for Retarded Children, and later to become a civil servant in the Ontario government for a few years in the 1970's)

*Although Bank-Mikkelsen is credited with the neologism "normalization," it is interesting to note that the concept had already appeared in the professional literature as, for example, in a 1940 article in the *American Journal of Mental Deficiency* where Ernest L. Roselle of the Southbury Training School in Connecticut stated that "children have the unalienable right to be reared in conditions approaching as closely as possible those of a normal home and community." Of course, B.T. McGhie frequently talked in terms of normalization without using the word [See p. 123].

as "making available to the mentally retarded patterns and conditions of everyday life which are close as possible to the norms and patterns of the mainstream of society."[8]

As Wolf Wolfensberger points out, Nirje was primarily concerned with the application of the principle to the design and operation of residences for the retarded, but others saw that it could be used to define both the process and the goals of mental retardation policy generally. Thus, Wolfensberger defined it as: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours which are as culturally normative as possible."[9] Wolfensberger also warned that the term "normalization" was deceptively simple, and as a result much of his book on normalization is devoted to explaining how it should apply to the various aspects of mental retardation policy. However, by the 1970's the concept of normalization had become an established part of the vocabulary of mental retardation policy.

Another particularly important influence on thinking about mental retardation policy in Ontario was Wolf Wolfensberger's appointment as Visiting Scholar at the National Institute on Mental Retardation located on the campus of York University just outside Toronto. Wolfensberger had a profound effect on those who came into contact with him, with many people speaking of being "converted" to his views. As a result of working with Wolfensberger, or listening to him, many parents and volunteers who worked in the field or who belonged to local associations came to believe that the large institutions were the embodiment of everything that was wrong with mental retardation policy and that the major goal of all those working in the field should be to get people out the institutions and into a community setting as quickly as possible. In one sense, Wolfensberger was a "moral entrepreneur" like Helen MacMurchy in the early 1900's. The difference was that Wolfensberger fought against institutionalization with the same skill and vehemence that MacMurchy had brought to the struggle *for* institutionalization some sixty years before. Moreover, Wolfensberger argued that in sharing responsibility with the government for the financing and administration of such community services as group homes and sheltered workshops, the local associations were gradually being coopted by the government and would be increasingly unable to play an objective, critical role. One official from the National Institute on Mental Retardation said: "We understood that when he came he was going to create much reaction and hostility but we needed someone who could train people, who had the missionary commitment, who was still objective and effective. We knew he would alienate a lot of people. . . . And so in two years he did what most people don't do in twenty years. . . . And we just gave him a lot of support . . . it just gave the cause a fantastic lift. He attacked the government, he attacked the professions and local associations. But he was on pretty solid ground you know. You couldn't tear him apart."[10]

Thus, Wolfensberger's presence in the province during the years of the Williston Report meant that many OAMR members became deeply opposed to the perpetuation of the large institutions and increasingly committed to the concept of normalization. But they realized that deinstitutionalization and normalization were not necessarily the same thing. It was one thing to release mentally retarded people willy-nilly from large institutions, it was quite another thing to ensure that there were sufficient support services in the community to help them to live, work and function the same way as other citizens.

In this context it should be recalled that attempts to deinstitutionalize mentally retarded people by gradually integrating them into the community had been under way in Massachusetts since the beginning of the twentieth century, and that the idea of providing community services and facilities for mentally retarded people had been broadly discussed in the professional literature ever since the end of World War I. The major difference between the philosophy of normalization as Wolfensberger and his disciples expounded it and earlier ideas on deinstitutionalization and community integration, was that by the 1960's many people rejected the entire concept of maintaining large or even scaled-down institutions for mentally retarded people. Whereas before the 1960's the institutions had been viewed as an alternative to community care, with community care justified mainly because there seemed to be no end to the requests for bed space in large institutions, now community care was justified as the best, the only method for caring for mentally retarded people.

One of the reasons for the increasing influence of the idea of normalization was that there had been a gradual shift in influence over the conceptualization of policy away from physicians and psychiatrists, and toward a heterogeneous group composed of sociologists, social scientists and an important minority of critical psychiatrists. Many of these people came from universities and comprised part of what sociologist Daniel Bell has called the "knowledge élite," that is, people whose influence in society stems not from their possession of scarce goods, money or capital but from their ability to structure the way we think and talk about social problems. Critics such as Erving Goffman, R.D. Laing, Thomas Szaz, and, in the field of mental retardation, Wolf Wolfensberger, began to question the rationale of the medical and psychiatric models as applied to mental health and mental retardation policy. The continued failure of the big institutions to alleviate the problems they were supposed to solve, the increasingly accepted view that mental illness and mental retardation were problems of "labelling" and deviance rather than problems of physical or mental disease, all combined to undermine the position of physicians and psychiatrists, and to support the notion that the problems of mental illness or mental retardation lay not in the mentally ill or mentally retarded themselves, but in societal attitudes toward them.

But there were certain ironies latent in these views. It is true that physicians and psychiatrists had historically played a key role in defining what

mental retardation was and in the actual administration of mental retardation policy. But the pattern of care for mentally retarded persons has been significantly different from the pattern of care for the physically ill. Whereas sick people are cared for on a short-term basis in general hospitals, large numbers of mentally retarded people spend their entire lives in enormous, impersonal custodial institutions. While general hospitals are governed by private boards regulated by the government, in Ontario large mental retardation facilities are under the direct control of government. Whereas the physically ill usually do not suffer stigma from the fact of illness, mentally retarded people have traditionally been stigmatized either from being labelled as retarded, or from spending time in mental retardation institutions or special classes or schools. Moreover, in terms of quality of care, level of funding, after-care services and institutional amenities, there can be no question that mentally retarded persons (as well as mentally ill, and incurably or chronically ill people) have always been treated much worse than physically ill individuals.

For more than a century, mental retardation policy was shaped by a variety of factors. Educators, social reformers, physicians, politicians and psychiatrists all played their role. At different times the keystone of mental retardation policy, the large institution, was asked to perform educative, or asylum, or social control, or social welfare functions. By the 1930's, however, the social welfare function of the mental retardation institution had become dominant. To say that what was being rejected in the 1960's and 1970's was a medical model of care is only partially correct. Certainly people no longer accepted the notion that mentally retarded people were "sick," that they should be "patients" in large custodial "hospitals," and that physicians and psychiatrists were best equipped to deal with their problems. But what was really being rejected was a particular variation of social welfare policy which had evolved under the aegis of the medical and psychiatric professions since the turn of the century.

Part of the confusion about the medical model of care derives from the fact that physicians played an extremely important role in policy-making in the nineteenth and early twentieth centuries. Their advice and options were often accepted in fields that had little to do with their expertise in the practice of medicine. Exactly why physicians were able to play this diffuse role, why they were able to extend the boundaries of their influence beyond the specific attributes of the medical role has to do with the history and sociology of medicine. But it is misleading to assume that the major problem with mental retardation policy was that it had for too long been subsumed under a medical model. The re-orientation of policy away from big institutions toward some form of community care can best be analogized with the early twentieth-century attempt to deal with the problems of unemployment and poverty by abandoning the workhouse and providing cash payments supplemented by government training programs or job employment schemes.

Until the postwar period, governments had attempted to deal with mental retardation in the same way as they had dealt with poverty at the turn of the century. It was assumed that the problem lay in the intellectual (or, in the case of the poor, the moral) deficiencies of the individual. The principal role of government was to ensure that those who could not cope with the demands of society, or who had been rejected by family or community had some final refuge to repair to in case of dire need. But the government could hardly be expected to "cure" these individual deficiencies. Of course, even during the nineteenth century it was gradually becoming apparent that social problems such as poverty and unemployment were due as much to the existing political and economic structure of society as to any inherent faults of the individuals concerned. However, it was not until the postwar period that people began to take such arguments seriously when applied to mentally retarded people. Thus mental retardation policy was an anachronistic monument to an institutionally-based social welfare policy that had long been abandoned in other areas of governmental policy-making.

From 1971 on, therefore, there was enormous ferment in the field of mental retardation policy. The Williston Report particularly had a profound impact as it circulated widely within the Ontario public service and throughout the various local associations for the mentally retarded. Time and again it was cited by government spokesmen in support of its policy (and later, against the government by opposition critics and the OAMR). According to Minister of Health A.B.R. Lawrence speaking in the Ontario Legislature on December 15, 1971: "I think . . . that we are moving with all deliberate haste in the direction of implementing the policies of Williston; the policies . . . that were really set afoot by the Minister of Health (Dr. Dymond) about nine years ago. . . ."[11] Lawrence may have been right in suggesting that Dr. Dymond had first sketched a policy of building smaller institutions and providing community support systems for mentally retarded people in the form of group homes and improved services, but by the government's own admission practically nothing had been done to provide community services for mentally retarded persons from the time of Dymond's "Blueprint" statement of 1964.[12]

Sixteen months after Lawrence's statement, Richard T. Potter, the new Minister of Health, tabled a series of recommendations dealing with mental retardation facilities in northeastern Ontario. In doing so he noted that they "will go a long way toward answering the needs outlined in the Williston Report."[13] In his discussion Potter noted that the government was developing a "master plan" which would lead to the "eventual replacement of our larger institutions by smaller community-oriented facilities." Potter also promised to reduce the population at Orillia by 50 percent from about 2,000 to 1,000 over the ensuing five years. (In 1972 there were 1,868 residents in Orillia, in 1977, 1,243, a decline of 33 percent.) As a first step Potter noted that 200 "patients" who came from southwestern Ontario would be transferred to the Oxford Mental Health Centre in

Woodstock. Quite clearly at this stage the government interpreted its mandate to phase down the large institution in terms of transferring people from facilities such as Orillia to "smaller" facilities such as Oxford which in 1972 had approximately 600 residents. Moreover, Potter also demonstrated the government's continuing commitment to the large institutions by noting: "We will also improve some of the existing buildings [at Orillia] to give more dignity to those patients who still need long term residential care in the hospital school."[14] Finally, Potter noted that the government was going to purchase facilities formerly used by the armed forces in Oakville and at Cobourg for use as residences. Here the government was following a practice that had originated with the first attempt to use an abandoned hotel in Orillia as a mental retardation institution in 1861.

For over 100 years government officials in Ontario seem to have been irresistibly attracted to the idea of using abandoned hotels, ex-religious institutions, or unused army barracks to house mentally ill and mentally retarded people. With rare exceptions, ostensible policy objectives such as "curing" the insane or retarded, education or normalization did not determine the choice of structure. Rather the desire to get the cheapest possible accommodation meant that the government subordinated the needs of the retarded to the demands for economy. These choices did not derive from callousness or lack of sympathy for mentally retarded people, although there has certainly been some element of that over the years, but mainly from government trying to mediate between the demands of humanitarians arguing for improved services, and the internal demands in government for economy.

Thus in 1971 the Department of Health seems to have interpreted the Williston Report quite narrowly as supporting a reduction in the size of large institutions rather than advocating a complete re-orientation of policy away from institutions toward a system of community care. On May 23, 1972, Potter announced that the government would not build any more large institutions (reiterating a promise made by Dr. Dymond some years before) but that mentally retarded persons would be placed in "smaller institutions." As an example, he cited Picton, another institution which had been opened on the site of a former radar station and which was intended ultimately to house 600 mentally retarded residents.[15] Ironically, one of the high civil servants in the Ministry of Health who supported the idea of using the air force base at Picton justified the choice by saying that the intention was to create an "instant institution" which could be opened quickly, would cost much less than big, permanent institutions, and would then "self-destruct" in a few years when alternate facilities were available. Far from self-destructing, Picton housed 375 residents in 1980.[16]

The Report of the Committee on Government Productivity

While all this was taking place, in February 1972, Angus Robertson, the President of the OAMR and several members of the OAMR Board of Directors met with Premier Davis and the newly appointed Provincial Secretary for Social Development, Robert Welch, to discuss the implications of the Report of the Committee on Government Productivity (COGP) for mental retardation policy.[17] The COGP had been appointed in 1969 at a time when, as the authors pointed out, the province of Ontario had become the third largest employer in Canada and the largest employer in the province.[18] Government expenditures had been increasing rapidly: they had increased twenty-two times from $235 million in 1949/50 to $5,216 billion in 1970/71 while the proportion of the gross provincial product comprised by government expenditure had increased from 3.6 to 15.2 percent in 1961 dollars.[19] Yet neither the government nor senior civil servants were clear about how or why expenditure decisions were made, while lines of authority were blurred within and among government ministries.

In order to take stock Premier Robarts appointed the COGP in 1969 and over the ensuing years it published a series of recommendations dealing with all aspects of the structure and management of government. Most important with regard to mental retardation policy was a recommendation contained in the Interim Report Number Three that "a new kind of Minister is needed — one who is completely free of the responsibilities and burdens of the chief executive of a department. Such Ministers would be called Policy Ministers."[20] These policy ministers, along with the chairman of a newly created Management Board (ex-Treasury Board), the Minister of Finance and Intergovernmental Affairs (ex-Treasurer) and the Premier as Chairman would make up the Policy and Priorities Board of Cabinet. According to the COGP, the policy minister "would have the responsibility of providing leadership in the development of policy for reasonably separate and distinct areas of public affairs, which we propose be called policy fields." Thus, the policy ministers would be mainly concerned with developing the broad lines of policy and shaping priorities among the various departments (or ministries as they were to be called), while the ordinary minister would continue as the "chief executive" with the major responsibility for the implementation of policy.[21] It was hoped that the policy ministers would bridge the gaps between ministries which often performed similar, or overlapping functions, and would help to bring together ministries which should have been cooperating toward common goals but which for personal or historical reasons were at odds with each other. In some ways, the creation of policy ministers and a policy and priorities committee at Cabinet level was similar to the establishment of interdepartmental committees. However, whereas the latter often foundered because departmental representatives frequently lacked the authority to commit their department to new

policy initiatives, the policy ministers' influence was supposed to derive from their membership on the Policy and Priorities Board and from chairmanship of policy field committees consisting of the policy minister plus the ministers within the field.[22]

As a result of the COGP recommendations, three policy fields were defined: Justice Policy, Resources Development Policy and Social Development Policy. The latter included the Ministries of Colleges and Universities, Community and Social Services, Culture and Recreation, Education and Health. Robert Welch was named Minister of Social Development Policy on January 5, 1972.

The appointment of Welch was a stroke of good luck for the OAMR. As Minister of Education in 1971, Welch had been in contact with the OAMR regarding schools for mentally retarded children, while his wife had been involved in a local association and had worked as a volunteer at a nursery and in a parent relief program. Thus Welch was personally acquainted with and interested in the question of mental retardation. By this time as well William G. Davis, the Minister of Education who had done so much to integrate the association schools into the public school system in 1969 had become Premier and by virtue of this post Chairman of the newly created Policy and Priorities Board. The result of these changes was that Welch was put into a position where he oversaw the activities of the Ministry of Health which had responsibility for mental retardation policy, as well as the Ministry of Community and Social Services which was shortly to become the new home for mental retardation policy.[23] Although it has been argued that the policy ministries never fulfilled their original mission, Robert Welch's brief tenure as Provincial Secretary for Social Development had a major impact on the shape of provincial mental retardation policy.

Shortly after the February 1972 meeting between Angus Robertson and other board members of the OAMR, Provincial Secretary Welch and Premier Davis, Welch appointed a task force to reconcile three studies that had been done on future mental retardation services for northeastern Ontario: an internal study done by the Ministry of Health which advocated building a 400-bed institution in Sudbury; another study done by a task force on mental retardation which reported to the Minister of Health in April 1972 and advocated broadening and extending community services by establishing three 50-bed and one 75-bed institution; and the Williston Report. Welch's task force was headed by H. Jackman, at that time senior policy advisor in the Provincial Secretary's department. The other members were Dr. Donald Zarfas from the Mental Retardation Services Branch of the Ministry of Health plus representatives from the Ministries of Education, Community and Social Services, Treasury, Economics and Intergovernmental Affairs (TEIGA) and the Management Board Secretariat.

According to one of the participants on the Task Force, the problem was to reconcile the different viewpoints expressed in the various

studies, to decide whether to move ahead on building additional institutions or whether to move in a major way toward increased community programs. But Welch's Task Force had already accepted the implications of normalization and now had to confront the fact that the Ministry of Health was deeply committed to the big institutions while the Ministry of Community and Social Services (COMSOC) was the only ministry at that time which had any responsibility for community-based services for mentally retarded people. Another participant in the Welch Task Force discussions also noted that the Mental Retardation Services Branch in the Ministry of Health was about to be broken up as a result of the COGP Report and was to be tied in more directly with the Ministry of Health.

After some discussion in March 1973, the Task Force produced a detailed statement of the current state of mental retardation services in the province and a sketch of future alternatives. Welch then decided to present it in the form of a Green Paper, a concept new to the Ontario government but which was based on the British concept of Green Papers as discussion documents. The Paper was called "Community Living for the Mentally Retarded: A New Policy Focus."

The Welch Green Paper

In many ways the Green Paper is a remarkable document, both because of its frank discussion of the existing deficiencies of mental retardation policy and because of its explicit, detailed commitment to a reorientation of policy toward community care for mentally retarded persons. In retrospect it seems that the authors were much too optimistic about the pace at which the province could move in the direction of community care, but it is clear that at the time they were fully committed to this approach. The very first page of the Green Paper explicitly committed the government to improving community facilities for mentally retarded people. "Wherever feasible, services should be provided in a community setting as an alternative to institutionalization...since a life of normalcy is our goal in caring for the mentally retarded a full range of services will have to be provided in the community."[24]

The report then launched into a surprisingly frank attack on existing government programs and criticized a lack of progress toward the provision of community services, a policy which had been advocated by every single report dealing with mental retardation and mental health policy since 1950, and which had been strongly supported by B.T. McGhie in the 1930's. Among the reasons for the lack of progress toward fuller community services, the report cited the same lack of coordination among ministries that Williston had criticized. Responsibility for the delivery of services to retarded people was scattered across six different ministries: Health, Education, Community and Social Services, Labour, Colleges and Universities and the Attorney General. The lack of coordination was particularly noticeable among the main service providers:

Health, Education, and Community and Social Services.

The report also noted that: "Some government policies also appear to be unintentionally encouraging the perpetuation of institutional care." This stemmed from different methods and levels of funding as between the Ministries of Health and Community and Social Services. For example, whereas the government funded 100 percent of capital and operating costs for the big institutions, in 1973, it paid only 50 percent of the capital and 80 percent of the operating costs for community residences under the Homes for Retarded Persons Act. In addition, while the Ministry of Health paid the full cost of sheltered workshop programs in institutions, COMSOC paid only 35 percent of the cost of sheltered workshops outside institutions.

The Green Paper criticized the sheltered workshop program, noting that mentally retarded people worked almost exclusively with other mentally retarded people in a segregated setting, while wages which worked out to between three cents and eleven cents per hour were scandalously below the minimum wage. An additional problem was that if the wages had been raised this would have led to reductions in family benefits payments. Thus there was little incentive to increase wages. Yet, according to the Green Paper, "the objectives of income and employment policy should be to normalize the relationship between income and employment, as far as this is possible, and to maximize the degree of control that the retarded person, his family, or his guardian has over public expenditure for his support."

The Green Paper suggested that industries be subsidized to an amount equal to the public cost of welfare maintenance, plus the cost of keeping a person in a sheltered workshop. In this way the employed retarded person would be able to retain what he earned over that amount. It also recommended that subsidies be granted to those businesses which employed retarded people with lower-than-average productivity or that the Ontario public service undertake to employ retarded people.[25]

The Green Paper then examined four proposals regarding the administrative structures involved in the delivery of mental retardation policy: 1) that a specific agency or department be created with responsibility for coordinating all services to handicapped people; 2) that responsibility for all institutions for retarded people be transferred from the Ministry of Health to COMSOC; 3) that better coordination among ministries be achieved through defining their roles more specifically; and 4) that local agencies be created with full responsibility for providing mental retardation services in a community. But it noted that one major obstacle to having a single agency for handicapped people was that ministries were organized along functional lines and were not oriented toward particular client or target groups. "Creation of a ministry for the handicapped would, in itself, be a form of institutionalization segregating handicapped citizens from other citizens in Ontario."[26] One obvious but unstated reason for opposing this suggestion was the possibility that such

a ministry would have come under intense pressure from the very clients it would serve. Providing services to one or another group in a ministry which performs a number of different functions means that pressure groups with similar interests are unlikely to effectively concert their activities toward a common goal, or in the last resort, to "capture" the ministry so that it acts in favour of one particular interest.

The suggestion that there be more coordination among ministries seems to have been included merely to pad out the list of proposals, but the suggestion of establishing community boards or agencies to deliver services for mentally retarded people was quite serious. However, the Green Paper noted certain disadvantages: there would be difficulty in "arousing community interest to the point of participation in the board, and in obtaining coordinating staff and it would be inconvenient to deal with many agencies of the Provincial Government."[27] Here, too, there seem to have been some unstated objections. To have given over total responsibility for the delivery of services to a local agency would inevitably have provoked conflict between Queen's Park and the agency over funding and over the goals to be pursued. Moreover, local agencies are quick to complain about insufficient funding, while the civil servants at Queen's Park were sophisticated enough to realize that funds for providing community services might someday have to be cut back, in which case local agencies dedicated to providing services would inevitably have been a thorn in the side of the provincial government.

Finally, the proposal to transfer responsibility for institutions from Health to COMSOC would, the Green Paper suggested, "encourage the phasing down of institutional use and development" (although the Report does not make it clear why this should be so), and would make it possible for the province to obtain federal cost-sharing funds through the Canada Assistance Plan (CAP). The one major disadvantage mentioned was the possibility that "placing responsibility for institutions with [COMSOC] may be considered incompatible with its current responsibility to develop and support community-based programs."

Finally, in their conclusion the authors of the Welch Report came down squarely on the side of phasing down large institutions, providing services in the community, ensuring that "wherever possible" mentally retarded children would be cared for in their families and encouraging the community to ensure "the full development of the social and employment potential of the retarded adult."[28]

After the draft was completed it was sent to the Cabinet Committee on Social Development, a new body which had been established as a result of the COGP report. The Committee consisted of the Ministers of Colleges and Universities, Health, Education, and Community and Social Services. The Committee recommended to Cabinet that "the government should endorse the principle that care systems for mentally retarded persons should be primarily provided in a community setting, rather than in remote institutions," and it also recommended that the principal sug-

gestions of the Williston Report be implemented.[29] From the Cabinet Committee the report was sent to the Cabinet which approved it at about the same time as Robert Welch had a speaking engagement before the Metropolitan Toronto Association for the Mentally Retarded.

At this meeting in April 1973, Welch presented his Green Paper. One account of that meeting notes that there was a momentary silence after Welch's presentation, and then a standing ovation. "The Green Paper confirmed that there was agreement between associations and government on principles which could form a solid base for implementing community programs and thus provide normalizing opportunities for retarded people."[30] Additional responses to the Green Paper were then solicited during the spring and summer of 1973. In May, 1973 the OAMR responded with a two-page statement about the Green Paper. The OAMR recommended that a Ministry for the Handicapped responsible to the Provincial Secretary for Social Development be established and that falling short of that, responsibility for mental retardation policy be transferred from Health to COMSOC. In the latter case, OAMR recommended that a Mental Retardation Division be created which would report to the Deputy Minister of COMSOC. The OAMR responded favourably to the suggestion that community boards responsible for service delivery be established, and it recommended that such boards be established for a three-year trial period. But it also recommended that an equal number of boards be established using OAMR local associations, that they be funded on the same basis as the community boards, also for a three-year trial period. At the end a joint advisory council with members from government and the OAMR would evaluate the relative performances of the two service delivery systems. Exactly how these two systems were to function was not spelled out in the OAMR document, and in any event, the experiment was never attempted. The OAMR also recommended "that the policy with regard to development of resources for residential services remain flexible so that a variety of living plans can be developed," and it endorsed Welch's suggestion that subsidies be given to industry to hire retarded persons.

At this point in the evolution of policy, the "Rashomon effect" enters in, for there are a number of different versions of the event that led to mental retardation policy being transferred from Health to COMSOC. However, there seems to be agreement that the actual decision to make the transfer was negotiated at an evening meeting between Provincial Secretary Welch and the various Ministers in the Social Development policy field. At least two civil servants who were involved in that transfer maintain that Welch raised the matter in an almost casual fashion during the meeting, and that none of the other ministers present really grasped the full implications of the decision. One civil servant maintains that Welch had thought very carefully beforehand about how to get agreement on what he knew would be an extremely important and difficult matter.[31] Whatever the exact circumstances of the move, sometime in the summer

of 1973 an agreement was reached that responsibity for mental retardation policy (apart from education) would be shifted from the Ministry of Health to the Ministry of Community and Social Services.

The Canada Assistance Plan and the Shift to COMSOC

In addition to the Williston Report, the acceptance of the philosophy of normalization and the influence of the COGP reorganization, one other extremely important factor militated in favour of the switch, for in shifting responsibility for mentally retarded people from Health to COMSOC, the provincial government became eligible to receive cost-sharing funds under the Canada Assistance Plan (CAP).

The Canada Assistance Plan had been introduced by the federal government in 1966 and provided for a 50 percent reimbursement of provincial social assistance expenditures for persons "in need." CAP effectively replaced a number of previously separate programs of old age assistance, blind persons' allowance, unemployment assistance and disabled persons' allowance. It was under the latter plan that mentally retarded people in the community had received social assistance payments from the provincial government.[32] However, mentally retarded people who were in institutions under the provincial Mental Health Act were not eligible to receive CAP-assisted funds.

In the late 1960's senior civil servants in New Brunswick conceived the idea of transferring administrative responsibility for mentally retarded people from the Ministry of Health to other ministries, thereby removing them from under the mental health legislation, and making them eligible for CAP funding. In 1973 Robert Welch and some of his senior civil servant advisors began to argue that a similar administrative change in Ontario would give mentally retarded people access to CAP funding. It was also argued that since COMSOC already had responsibility for the Homes for Retarded Persons Act, Day Care and Developmental Centres, Sheltered Workshops and other social programs such as Homes for the Aged and Children's Homes, and since it already administered the various provincial social assistance plans, the ministry was the natural place to house programs for retarded persons.

It is hard to know whether the switch to COMSOC came about because of the desire to gain access to CAP funds, or whether it would have occurred in any case. There was no agreement on this question among those interviewed, including some of the civil servants closely associated with the switch. But the fact remains that in Canada, the U.S. and in Great Britain, there was a shared feeling among those interested in and responsible for mental retardation policy that the time had come to reduce the size of large institutions, and to establish some kind of community service program for mentally retarded people. What is interesting is that in the U.S. as in Canada, social assistance programs established initially as social welfare measures (Medicaid and Supplemental Security Income enacted in 1965 and 1972 in the U.S., and CAP enacted in 1966 in

Canada) were eventually taken up by large numbers of mentally ill and mentally retarded people, something which had not been contemplated when these programs had first been established. The reason was that mentally ill and mentally retarded people were initially labelled as "sick" or "ill" and were under the responsibility of health departments. With the rejection of the medical model both groups gradually began to fall within the purview of social welfare programs, particularly as increasingly large numbers were discharged from institutions into the community.[33]

Mental Retardation Policy Comes to COMSOC

The actual transfer and the ensuing policy process took place in an atmosphere of some confusion and great uncertainty.

First, an attempt was made to formulate general policy objectives through the production of various discussion papers, reports and position papers. This provided a theoretical background to the attempt to re-orient mental retardation policy. Second, once the transfer had taken place, a period of conflict ensued within COMSOC as civil servants argued over the future direction of policy.

All those concerned with the transfer were aware of the complexity of the task involved, and of the inevitable frictions and difficulties that would arise. The immediate problem arose from the fact that the Ministry of Community and Social Services, with a complement of approximately 2,000 people, and a primarily service orientation, was being asked to absorb an additional 7,700 staff members scattered throughout twenty-nine different institutions housing approximately 12,000 mentally retarded residents.

Traditionally COMSOC had concentrated on administering the various provincial social assistance or income security programs. Now it had to absorb an immense new structure of policy-making including an institutional component that dwarfed existing COMSOC activities in the homes for retarded persons and children's services programs. Curiously enough, although the various studies concerned with the transfer of mental retardation to COMSOC looked into a variety of potential problem areas, none mentioned the possible difficulties that might arise as the government sought to phase down the large institutions with their 7,700 employees. For example, the report of the Hickling-Johnston consulting firm hired by the government to advise on the transfer, talks of "winding-down" the large institutions, but its major preoccupation was with how the government would deal with staff unions. They point out, for example, that in the Ministry of Health the staff at one institution traditionally compared their position with the staff at other institutions. Thus, Hickling-Johnston warn against the possibility of "whip-sawing" by the unions unless the government took care during the transfer not to provoke one group of employees into making invidious comparisons with other groups. But there is no mention at all of the resistance that might arise from the unions if jobs were threatened by the long-term goals of de-institutionalization, or from municipalities threatened by the loss of a

major employer.[34]

For a discussion of some of the most interesting problems involved in the proposed administrative and policy changes one must turn to the report of the Programs and Operations Task Force, drafted by a committee of top civil servants from COMSOC and the Ministry of Health.[35] There, the civil servants involved in planning for the future raised the question of a possible public reaction to apparent changes in mental retardation funding policies. According to the authors, the public incorrectly assumed that mental retardation institutions were funded out of the health insurance program because when a resident was admitted to an Ontario facility his health insurance number was recorded. Actually this was done in the event the patient became sick and had to make use of the health services. But most people did not understand this. In addition, in the event mentally retarded people in provincial institutions became eligible for cost-sharing funds under CAP, there would have to be a program of needs testing, something which the institutions had hitherto ignored. "Many low income families will be frightened by the prospect of a fee for service though in fact they would likely be exempt from it. Also, they could be concerned about needs-testing and possibly non-ward agreements for services to children."[36] Thus, the authors said, the shift from a universalistic scheme whereby services were available to all on the basis of need, to a selectivist system whereby services were available on a needs- or income-tested basis would need skillful handling if the public were to accept it.

In any event, however, these fears were exaggerated, mainly because when the transfer took place it turned out that very few mentally retarded people who were over eighteen and thus eligible under CAP for cost-sharing had resources which made them ineligible for assistance.[37]

Another problem area mentioned by the Task Force, and one that has continued to plague government, concerned differential levels of funding among various provincial residential facilities. For example, the authors pointed out that whereas the government provided 100 percent of operating costs for Schedule II institutions (these were mental retardation facilities for severely and profoundly retarded persons funded by government but operated by community boards), it only provided 80 percent of the operating costs for community residences and day nurseries. It was suggested that the unevenness of funding be "clarified."[38]

In addition to being concerned with the philosophy and level of funding for mental retardation programs, both Hickling-Johnston and the Task Force raised, but did not answer the question of how the government was to deal with the large numbers of mentally retarded people who were not in provincial mental retardation facilities, but scattered throughout a variety of additional facilities. For example, according to Hickling-Johnston, in 1973 there were approximately 2,350 mentally retarded people among the 7,427 residents of the Homes for Special Care; 400 mentally retarded children in eleven nursing homes for mentally retarded

children; 1,500 adult mentally retarded people in 238 nursing homes, 450 in 241 residential homes, and 2,000 in psychiatric institutions. At the same time in 1972/73 there were 6,821 mentally retarded people in the Schedule I and Schedule II mental retardation facilities. Thus there were almost the same number of mentally retarded people under provincial care in facilities which might remain unaffected by the transfer of mental retardation services from Health to COMSOC as there were in mental retardation facilities. Hickling-Johnston noted that it would be possible to regroup the mentally retarded residents in the Homes for Special Care and transfer them to COMSOC, but, they warned, "this will require careful study considering the disruption involved."[39] The Task Force authors noted that personnel associated with the mental retardation program argued that the Homes for Special Care program should be transferred since it was "essentially a community based program and is a crucial component in their range of services."[40] In any event, the Homes for Special Care program was not transferred, with the result that absolutely nothing was done for these people in the way of additional care or programming until 1980.

These were some of the major concerns raised just prior to the transfer. And although problems with philosophy, funding and clients were to remain, in the immediate aftermath of the switch, problems of a quite different nature were to occupy the attention of the politicians and civil servants concerned with mental retardation policy.

In October 1973, Minister for Social Development Policy, Robert Welch noted that the decision to transfer care for mentally retarded people was consistent with the "cabinet's decision that systems of care for the mentally retarded should be primarily provided in a community setting rather than in institutions."[41] On April 1, 1974, the Developmental Services Act of 1974 went into effect spelling out the details of the now-reorganized Ministry of Community and Social Services.[42] The Act prescribed that people originally called "patients" under the Mental Health Act would be discharged from psychiatric facilities and admitted as "residents" under the new Act. By this simple administrative change, mentally retarded people in various provincial facilities qualified for benefits which were subsidized under the Canada Assistance Plan.

Shortly after the transfer took place, there were some important changes in COMSOC. Miss Dorothea Crittenden, who had been Assistant Deputy Minister, was promoted to Deputy Minister. At the same time, a division of responsibility took place among civil servants who came over to COMSOC from Health. Dr. Ron Farmer, who had formerly been in charge of the facilities under the authority of Dr. Donald Zarfas while in Health, was put in charge of the new Mental Retardation Facilities Division, with Dr. Zarfas taking the role of Consultant. Simultaneously, David MacCoy, an ex-social worker, was put in charge of Mental Retardation Community Services Development.

Establishing Administrative Structures

Initially, there seemed to be consensus within COMSOC over the desirability of reducing the size of the large institutions and elaborating an extensive system of community care for mentally retarded people. All those associated with mental retardation policy seemed united in the belief that the funding and administration of community programs should be shared between government and voluntary organizations, particularly local associations for the mentally retarded. But the seeds of conflict lay buried in this approach, for the apparent agreement on shared responsibility hid the fact that two quite different, and in the end, conflicting objectives were at issue. Among the civil servants in the community development branch and in other areas of COMSOC associated with community development, it was felt that the participation of voluntary organizations in mental retardation policy would lend a degree of flexibility and sensitivity to local needs that had been glaringly absent from mental retardation policy in the past. But for others, the reluctance to see the government fully fund and administer community programs stemmed from a fear of committing the government to a program whose ultimate financial costs were unknown, which might turn out to be politically sensitive, and which was increasingly seen as linked to social welfare policy, not a high priority area for the Progressive Conservative party.

One of the first documents to be produced was the "Discussion Paper on a New Mental Retardation Program for Ontario" (or the "Avocado" Paper, after the colour of the cover). Since Premier Davis was scheduled to speak to the annual conference of the OAMR in Peterborough on May 16, 1974, the civil servants associated with the Mental Retardation Community Services branch were asked to produce a policy paper on the new community thrust. Premier Davis would then use this paper as a basis for his speech. One of the authors of the paper recalled that the drafting committee barely had time to sketch their ideas and have the paper typed before Davis delivered his speech early in May. The Avocado Paper was drafted by four members of the community services development branch: David MacCoy, John Webster, John Cargo and Ross Thorpe, and it clearly reflected their thinking about community programming.

Perhaps the most dramatic statement in the paper concerns the "return of all rehabilitatable persons to their own communities (currently estimated at 50 percent of the present population) within five years."[43] Although Williston had mentioned phasing down the large institutions to 40 percent of their capacity, various government spokesmen seem to have settled on the 50 percent figure by 1972. Exactly how they arrived at that figure is not clear. One high civil servant, Alan Gordon, who was Assistant Deputy Minister for Program Development in COMSOC in 1974, was quoted as saying it was "a nice round figure."[44] But the authors of the Avocado Paper also noted that some people felt the 50 percent figure was too high. (As it turned out there were 6,048 residents in the large Schedule I facilities in 1973, and 5,953 five years later, a reduction

of 1.5 percent.) Moreover, the authors cautioned that the large institutions could not be "abolished in entirety" in the foreseeable future since they were the focal point of care for severely retarded people. However, while "community residences, home support services, day care programs and other supervised living and training situations" would be developed, the large institutions would be phased down. Simultaneously "a full range of programs and services will continue to be developed and provided within the facilities and normalcy as far as this is possible in the facility will be the major premise of the operation."[45]

One of the administrative innovations suggested in the paper concerned a new organization to plan the development and delivery of community services for mentally retarded people — the district working group. The idea itself was not new, for a Task Force on Community and Social Services (on which David MacCoy had served in 1973) had already recommended the establishment of twenty COMSOC administrative districts for the delivery of family benefits, vocational rehabilitation, and other Ministry services. In 1973, the notion was that "the Ministry should accept responsibility for the direct delivery of services only in those instances where no equally effective means are available elsewhere.... There is a large number of organizations, both public and private that comprise what we think of as the community and social service system of Ontario."[46]

In 1974, therefore, it was quite natural for the staff of the community development branch to suggest the establishment of nineteen mental retardation districts, each with its own district working group consisting of representatives from local voluntary organizations, local government and a government-appointed coordinator. Their assignment was to assess available community resources, to elaborate district plans for future developments and to coordinate the activities of the various bodies involved. According to the Avocado Paper, their goal was "coordination and partnership based on mutual objectives among delivery agents and interest groups [which] will constitute a Mental Retardation Program delivery coalition."[47]

In his speech to the OAMR on May 16, 1974, Premier Davis did not mention the suggested district working groups, but he did commit the government to play only a limited role in the future development of community services for mentally retarded people. "I know," he said, "there are some people who would suggest that...the government should perhaps take over the total responsibility and the total initiative. I would make this observation to you that if this had been the case fourteen years ago we would never have made the progress as a society in this province if it had been left entirely up to government." In the same speech Davis also made what later became known as the "Peterborough commitment." "The only thing that I can tell you and make it abundantly clear is that whatever funds flow through the agreements with Ottawa to the province of Ontario will be without question allocated in total to the programs re-

lated to the mentally retarded."[48]

Davis' speech gave the seal of approval at the highest level to the concept of community participation in the administration and funding of community programs. In a discussion paper that followed Davis' speech and was published in September 1974, it was emphasized that:

> The role of community involvement in the promotion of the planning and development of community resources and service networks for the retarded is critical. It is felt that regional differences and preferences within the Province can only be expressed by local people, and furthermore, that ideas, preferences and plans will prove more accurate and effective if they flow upward from the community to the government. If local social services are to be relevant it is necessary to have the support of local citizen volunteers. It has been shown time and time again that programs that are totally government operated and controlled do not truly become part of the community — citizens have no investment in them.[49]

By the fall of 1974 those associated with the development of community services had developed an elaborate justification for their approach. They argued that if community services were directly run by the provincial government, they might be subject to the vagaries of government financing and suffer from cutbacks in funding during times of economic stringency. Thus the participation of voluntary organizations and local governments could cushion economic shocks. Some people in COMSOC were also suspicious of the large facilities and feared, correctly as it turned out, that the civil servants associated with the big institutions might attempt to resist or even undermine the community development thrust. Here too, it was argued, involving local communities and organizations in the district working groups could provide a political base from which to resist possible obstacles that might be put in the way of community development. In addition it was argued that district working groups would provide an independent forum where local agencies could freely express their views and criticize government policy.

Hypothetically, of course, the administration and funding of community services might have been organized along entirely different lines. For example it would have been possible for the government to have established, operated and fully funded all community services including group residences, sheltered workshops, day nurseries and rehabilitation centres. After all, the large facilities had been administered and funded by the provincial government for over a century in Ontario. At the other end of the spectrum, the province might have left the entire burden of providing services in the hands of voluntary organizations. Or it might have followed the English example of calling on local governments to provide a full range of community services with voluntary organizations encouraged to fill the gaps in service.[50] But when questioned about the

latter possibility, civil servants pointed out that municipalities in Ontario traditionally have not been responsible for the direct provision of services, and that since their major source of revenue comes from property taxes, they would have strongly resisted such an imposition by the provincial government. When one senior civil servant was asked whether the Ministry had contemplated a plan whereby the district working groups might have been given responsibility for administering funds of their own, the response was that such move would have alienated local governments and created opposition among local officials.[51] If the district working groups had been given their own funds, it was argued, the provincial government would have been forced to maintain constant supervision over the groups and inevitably it would have been drawn into settling their disputes. Finally, it was argued, any funds given to the district working groups would have put money back into services that would have got the funds in the first place.[52]

There were other reasons as well which help explain why this arrangement was chosen for delivering community services to mentally retarded individuals.

As we have seen, in 1969 there was some reluctance among local associations to turn over their schools to the Department of Education. By 1974 many of those same local associations had re-directed their energies into the delivery of services such as day nurseries, sheltered workshops and the occasional group home. It is entirely possible they would have fiercely resisted any attempt by the government to take over and run these services. But no one in the OAMR or in the local associations ever suggested such a move. As one ex-president of the OAMR pointed out, the OAMR was then at the peak of its influence and prestige and it felt quite confident that it and the local associations could adequately deal with the task of delivering community services.[53] In addition, it would have been unlikely for the OAMR to advocate a policy which might undermine the role of the local association as the main provider of community services for mentally retarded people. Indeed, in September 1973, the OAMR had endorsed the government's proposals, recommending that the OAMR be involved "to a generous degree" in the district and regional services of COMSOC and that "representatives from the OAMR be included at the provincial policy-making level of Community and Social Services when policies affecting retarded persons are being developed."[54] Based on its past experience, the OAMR obviously expected to play a continuing and influential role in policy-making at Queen's Park.

In one sense, it was the large institutions which determined the direction taken by the community development thrust, for in taking the institutions as the model of "what not to do," the community development people argued that whereas the staff of the large facilities were all paid government employees, the participation of local associations for the mentally retarded in administering and funding community services

would bring unpaid volunteers and members of the community as well into contact with retarded people. Whereas life in the big institutions was impersonal and alienating, the community thrust supporters contended that life in group homes or apartments would bring mentally retarded people into contact with people in a human, normal setting. They pointed out that it was possible for a mentally retarded person to pass his whole life in an institution seeing only the staff or the other residents, whereas community integration would allow for the first time mentally retarded people to interact with all kinds of people.

So critical were many of these civil servants of the large institutions that, ironically, some were hostile to government itself and suspicious of any attempt to enlarge its role in policy-making. When asked whether they felt like civil servants, some of those who had worked in the community services development branch or were still involved in community programming admitted that, objectively speaking, they were, of course, paid employees of the government, but they did not "feel like civil servants." And as proof they would adduce their opposition to this or that attempt by COMSOC to extend its authority within the field of mental retardation.[55]

Some of the more thoughtful civil servants expressed a belief that collectivism and altruism were mutually exclusive, that is, once government got involved in running mental retardation policy the important emotional commitment of the unpaid volunteer disappeared from the equation. Thus their stated objective was somehow to combine the altruism of the local association with government funding and thereby steer a course between the Scylla of uneven provision of services and lack of support that plagued voluntary associations, and the Charybdis of impersonality and bureaucratic rigidity so typical of government control. But it soon became apparent that this goal was to be much more difficult to achieve than anyone realized at the time.

11

Conflict over Policy

Immediately after the shift of responsibility for mental retardation policy from the Ministry of Health to COMSOC there ensued a period of conflict, confusion and uncertainty as the civil servants in COMSOC maneuvered for position, fighting over different policy objectives.

The idea that political conflict occurs within bureaucracies is certainly contrary to the conventional wisdom about the relationship between ministers and civil servants, and among civil servants within a government department. It is often assumed that ministers in Cabinet formulate policy, while the civil servants carry these policies out. It is further assumed that civil servants contribute to the process of formulation by presenting a number of different policy alternatives to the minister, but that the civil servants themselves remain neutral as to which is the preferred choice, leaving the final decision up to their minister.

Of course, the actual relationship between civil servants and politicians is quite different. Over the years political scientists have noted wide variations in the degree of politicization of bureaucracies, from those which conform rather closely conventional ideas, to those where the civil servants play a major role in both policy formulation and policy implementation.

The Ontario civil service falls more on the politicized end of the spectrum. It is generally agreed that the Ontario civil service is extremely powerful and that senior civil servants wield most of that power. One respondent who played an important role in COMSOC after 1974 said: "Civil servants wield far too much power. They just wield unbelievable power, and the political guys, they don't know what is going on half the time. Once in a while you get a guy who does, but very seldom." These

sentiments were echoed to a greater or lesser degree by many of those who were interviewed.

There are a number of reasons for this. In 1974 the Progressive Conservative party had been in power in Ontario for three decades. This was longer than political parties in some of the so-called one-party regimes of the Third World. Civil servants who may have entered the Ontario public service in the late 1940's and early 1950's as junior officials had risen through the ranks to become senior civil servants. They had never known anything other than a PC government. Moreover, there is some question about the political allegiance of senior civil servants in Ontario. In the ideal model bureaucrats are supposed to be recruited and promoted on the basis of ability and achievement, rather than on the basis of "non-bureaucratic" qualities such as ethnicity, race, religion, or political party allegiance. Bureaucrats are often extremely sensitive to suggestions of political bias, for this threatens the basic assumption of neutrality in the civil service. But a number of people interviewed maintained that allegiance to the Progressive Conservative party was a prerequisite for promotion or appointment to the top ranks of the civil service, and they claimed that candidates for these posts were vetted by a top-level committee which included members of a prominent consulting firm with close ties to the PC's. Given the extraordinarily long tenure of the PC government in Ontario, and the assurance of general political support for the PC ideology, the various ministers who have filled Cabinet posts over the years have been confident that even if they allowed the top civil servants a wide degree of freedom in policy formation and policy implementation, there was little likelihood they would diverge too far from the Progressive Conservative ideology.

Civil servants often move from one ministry to another during their careers and a good civil servant will often make friends and allies as he moves through the corridors of power at Queen's Park. Frequently he can call on them for support or help. With many years of experience in a broad range of policy areas, it is not surprising that the top civil servants often become more knowledgeable than many politicians about the arcane ways of bureaucracy and the subtleties of policy. In addition, if knowledge is power, then power is knowledge. Because senior bureaucrats are perceived as powerful, interest groups try to gain access to the top ranks of the civil service. In doing so they will exchange information with the civil servants, thus adding to their power base. Moreover, the civil servants then can use this knowledge to argue a case before their minister, other influential politicians, or members of the civil service.

By contrast, the influence of politicians often pales beside that of the senior civil service. Ministers come and go in the Ontario government. Some are active, dynamic and innovative. Others prefer to play a neutral or even a passive role. In the large ministries such as COMSOC it is virtually impossible for a single person to keep track of everything that is happening within the various branches and divisions scattered around To-

ronto and throughout Ontario. Yet decisions have to be made and someone has to make those decisions. Inevitably, the senior civil servants play a major role in decision-making.

Moreover, a good deal depends on how clear policy objectives are. In those cases where they are explicit, easily understood, and where there are clear criteria of performance, then it is difficult for the civil service to depart too far from the stated objectives. But policy goals are often vaguely stated or couched in such general terms that they are subject to a variety of interpretations. This occurs because ambiguity is often the price of obtaining agreement. This also means that conflict over policy objectives will continue even during the process of implementation. This is what happened in COMSOC after 1974.

Unlike those cases of "policy termination" where authorities have agreed that a particular government agency, program or policy should be terminated, the new mental retardation policy orientation in COMSOC was the result of a compromise between different points of view, and particularly between those who wished to keep the large institutions from completely disappearing, and those who felt that the major thrust of mental retardation policy should be toward providing a wide array of community services, if need be, at the expense of the large institutions.[1]

Pierre Mendès-France, a former Premier of France, once said: "To govern is to choose." But it is equally the case that authorities can govern without choosing, for it is easier to govern if one gives the appearance of satisfying all constituencies in the process of policy-making and much more difficult to govern if policy choices clearly favour one interest over another. This is one reason why the Ontario government chose not to completely terminate the role of the large mental retardation institutions. But there was another reason. Both the concepts of normalization and deinstitutionalization were open to a variety of interpretations. For example, could mentally retarded people lead a "normal" life in reformed institutions? Certainly Wolf Wolfensberger would have argued vehemently against this idea, but there were many people who did so argue. In an article published in the British *Journal of Mental Subnormality* in 1970, Dr. Zarfas, then Director of the Mental Retardation Services Branch in the Department of Health, described the administrative reorganization of the large facilities along lines that would lead to mentally retarded people developing "more along the pattern of normal living." Among the major changes was the establishment of internal units of not more than 10 people. In addition, Dr. Zarfas noted that: "To move further toward the goal of normalcy, the Department has acquired two recently vacated relatively new military establishments. Both of these have a large number of single or semi-detached two- or three-bedroom residences for married personnel. These homes are being utilized as a residence for four or five retarded persons.... The author could not resist recommending the acquisition of these facilities despite their relative isolation from universities and large centres of population. The need to provide new

facilities to meet the waiting list pressures and reduce over-crowding was significant."[2] The use of the term "normalcy" in regard to the large, and later the so-called 150-bed "mini-institutions" is very interesting. Eugene Bardach has pointed out that one of the factors that facilitates policy termination is the "delegitimation of the ideological matrix in which the policy is embedded."[3] This was certainly the case as regards the ideological support for large institutions during the 1970's, for they were under severe attack from all sides. Indeed, one might argue that never was mental retardation policy so prominent in the public eye, never was government more concerned about policy and never was the OAMR more powerful than in the late 1960's and early 1970's when the large institutions were the universal target for all the accumulated grievances about mental retardation policy. Still, there were some people who felt that the large institutions had a valuable role to play, and they very skillfully adopted the vocabulary of their critics, particularly terms like "normalcy" and put them to work to serve the goals of institutional policy.

By late 1974, therefore, the lines of conflict within COMSOC were clear. On the one side there was Dr. Ron Farmer, the head of Institutions Operations. On the other side there was David MacCoy, the head of Community Services Development. And in the middle there was Dr. Donald Zarfas, now given a rather vague role as a program consultant for mental retardation policy. The conflict that then ensued was over policy, personalities and the style of administration within COMSOC.

The community development people and the facilities people were soon at odds with each other. Perhaps this was inevitable given the fact that both sides were competing for scarce funds, but it became apparent that the facilities people would resist scaling down the large institutions, and that they would actively seek a new role for the institutions in order to guarantee their future existence. On the other side, the community development people were convinced that the large institutions had a very small role to play in the future, and that resources should be devoted to the community development program. It was also apparent that the presence of Dr. Zarfas added a personal component to the equation. Everyone agreed that Dr. Zarfas was the most important single individual dealing with mental retardation policy in the civil service. To many he was "Mr. Mental Retardation." In the transfer to COMSOC, however, Dr. Zarfas lost the preeminent position he had within Health and was given a rather ambiguous role. But because of his immense reputation and because of his long years of experience in the field, many of those in the bureaucracy and in the community continued to seek his advice and support on key decisions. Due to Dr. Zarfas's long association with the facilities, however, some people in community development felt he was not as wholeheartedly committed to the new policy orientation as they were. Some senior civil servants in COMSOC were rankled by his continuing influence, despite the fact that his formal administrative position in the

bureaucracy was weaker than it had been in Health.

Finally, there was a good deal of conflict over the administrative methods of the Deputy Minister. Many of those interviewed claimed that the Deputy ran COMSOC in a highly personal, centralized fashion, forcing all decisions to be referred to her office for approval, encouraging civil servants to bypass the Assistant Deputy Minister, preventing any coordination among branches at a more decentralized level and promoting people mainly on the basis of personal loyalty rather than because of administrative skill or creativity in policy formulation.[4]

Inevitably, these problems were reflected in the implementation of policy.

The first indication of trouble came in the attempt to scale down the size of the large facilities, a specific commitment reiterated in various government policy papers after 1973. One problem was that the large facilities were being prodded by the Minister to reduce their resident population despite the lack of alternative community residences or group homes. Indeed, the administrator of the Huronia Regional Centre in Orillia claimed that he was threatened with firing by the Ministry if he did not reduce the resident population according to Ministry guidelines.[5] In 1975, for example, the target figure for reducing the size of the residential population in the large Schedule I institutions seems to have been 700. According to a *Globe and Mail* reporter, the Mental Retardation Facilities Division suggested that 100 people be transferred to a senior citizens' home in Toronto, but this proposal was withdrawn after the Metropolitan Toronto Association for the Mentally Retarded objected to this as a "ghetto-izing process."[6] Although some people involved in the OAMR at the time have suggested that the Facilities Division was deliberately trying to undermine the community development thrust by dumping unprepared mentally retarded people into the community, it may have been sheer lack of coordination between facilities and community development that led the large facilities to precipitately transfer mentally retarded people to smaller institutions, or to nursing homes scattered around the province.[7] In May 1975, Elie Martel of the NDP complained that despite Ministry promises that only bedridden people would be placed in a nursing home in Sudbury, approximately 100 ambulatory mentally retarded people, many from the institution at Cobourg, had been transferred to Sudbury.[8] The Minister, René Brunelle, admitted that there were problems with the nursing homes, but he argued that many of the residents were "very happy to be there instead of in the previous places," and he noted that they had been transferred so as to be closer to friends and relatives in the community. Martel responded by accusing the government of trying to cut down on costs, pointing out that the per diem cost of maintaining a person in an institution ranged between $37 and $45 per day, as compared with $17.50 per day in nursing homes.[9]

Early in the following year, COMSOC again ran into difficulty in its deinstitutionalization program, this time over an attempt to establish

what were called "resource centres" at two unused psychiatric facilities at Timmins and Goderich, the latter six miles from the town. What seems to have happened was that after the Ministry of Health decided to close the two facilities, some civil servants in COMSOC saw an opportunity to further reduce the population of the Schedule I facilities by transferring mentally retarded people to the now-abandoned psychiatric hospitals. The difficulty was that many people in the community, especially those associated with the OAMR argued that transferring mentally retarded people from large to "mini-institutions" was not in keeping with the philosophy of normalization and could not be justified as a move toward integrating people into the community. Within COMSOC, however, the civil servants associated with the large facilities contended that not all mentally retarded people could be integrated into the community, and that a substantial number of those with severe mental or physical handicaps would need the array of medical and social services which could only be provided in an institutional setting. They were supported in this by a certain number of parents in the OAMR.[10]

But civil servants in community development felt that some actions of the Facilities Division were specifically aimed at undermining the thrust toward community living, and particularly at the idea that retarded people were better off in small residential settings in local communities. Moreover, they claimed that the facilities people often bypassed the district working groups, and tried to give the appearance of deinstitutionalization without making any real policy changes. In a letter to P. Capps, the Executive Director of the Mental Retardation Community Services Development Branch, dated January 28, 1976, the London district working group recommended that Goderich not be used as a resource centre, claiming that the group had only been notified "after the fact" of the Ministry's decision. In a letter to the President of the Mississauga Association for the Mentally Retarded on February 13, 1976, the Minister, James Taylor (who had taken over from René Brunelle on October 7, 1975) noted that "the Government is prepared to respect the wishes of the District Working Group and will not proceed with the establishment of the Psychiatric Hospital as a community based Board operated Resource Centre." However, Taylor noted, since the facility was available, COMSOC had "decided to take advantage of the opportunity to use it as a Schedule I facility and thereby to ease some of the overcrowding in the large existing facilities."[11] Thus, whether they wanted it or not, the district working group in Goderich got a mini-institution.

By this time, the conflict within COMSOC had reached such a pitch that some civil servants were providing both the OAMR and some of the opposition MPP's, particularly those from the NDP who were thought to be particularly effective at the time, with information to be used against the large facilities.[12] This is not at all surprising, and only confirms the fact that when a political process takes place, whether it be in the community, in political parties, bureaucracies or other structures, the

usual tools of political action are used. Moreover, the only reason why those in the Facilities Division did not make equal use of pressure groups or parties was because they were still on the defensive and had few allies outside the facilities.

By late 1976, the public image of the large facilities was further damaged at Orillia where a series of beatings and murders in the spring of 1976 led COMSOC Minister James Taylor to appoint Dr. Joseph Willard to conduct an investigation of the institution.

In his report of November 18, 1976, Dr. Willard put forward a series of sixty-nine recommendations. Among the most important was the recommendation that the administrator of Huronia, Ralph W. Blakeman be replaced, and that residents at Orillia continue to enjoy the privilege of voluntary signing out or discharge. But in deference to the criticism that it was just this feature of Huronia that had allowed dangerous residents to wander abroad, Willard recommended that three special units at Huronia be designated as psychiatric units under the Mental Health Act, thus allowing for involuntary incarceration of dangerous patients. In the course of his extremely detailed report, however, Willard also discussed the future role of Huronia, and observed that in September 1976 the General Manager of the Facilities Services Division (Dr. Farmer) had suggested "that an immediate start would be made in the development of new and appropriate accommodation at Huronia. In his view this would include the construction of a 280-bed village complex for children and adults, and a new recreation and activity centre...."[13] At the same time, Dr. Willard also noted that only two years before, the OAMR and the Metropolitan Toronto Association for the Mentally Retarded had disagreed over a proposed 500-bed complex for Huronia, with the MTAMR supporting and the OAMR opposing further extensions to Schedule I facilities. Finally, Dr. Willard observed that the 1973 Welch Green Paper "represented a complete reversal of the Ontario policy of continuing dependence on large institutions. Instead, the new policy was to phase down large institutions and develop as an alternative, community-based types of accommodation."[14]

Quite clearly, mental retardation policy in 1976 was as confused as ever, for, as can be seen from the proposal to establish a 280-bed village at Huronia, the partisans of the large facilities were actively seeking new roles which would simultaneously conform to the new ideology of the time (normalization through reduction in the size of living units, provision of recreational facilities, a more "homelike" atmosphere providing greater privacy to the residents and more freedom of action), while also preserving the essential structure of the large institution (retaining existing staff but giving them new roles, improving or modernizing older buildings, constructing new buildings on the site of the facility, providing a variety of specialized medical or social services within the facility).

At the same time, no one seemed quite clear (or willing to make up their minds) about whether the Williston and Welch reports meant that

the large facilities should be phased down to the point where they would play a minimal, or no role at all; whether they should play a role during an undefined transition period during which community services would be developed so that they could take over from the large facilities, or whether they should continue to play an important, although different role from the past, moving from providing mainly residential services to providing alternate, short-term services. And complicating things even more was the fact that community services were still undeveloped, that they seemed unable to get off the ground, and that funds were scarce and were continually fought over by different groups in COMSOC. Outside COMSOC the local associations were also divided over the question of the large institutions and unclear about the ambiguities latent in the term and policy of normalization. Even the experts warned against a frontal attack on the large institutions. Dr. Benjamin Goldberg of the CPRI in London suggested: "We should be cautious in our thrust toward *de*-institutionalization that we do not become *anti*-institutional. All facilities for the retarded whether large or small should be part of an integrated network. In our enthusiasm for application of the normalization or behaviour modification philosophies of treatment, we should not ignore individual rights and needs, including the right to remain dependent."[15]

In this atmosphere the issue of the 150-bed "mini-institutions" continued to bedevil COMSOC. By 1977 the Ministry had opened 150-bed facilities at Timmins, Goderich and Oakville, and was proposing to build another 150-bed mini-institution in the Borough of Etobicoke in Metro Toronto. Unlike the situation which had obtained in Timmins and Goderich, however, COMSOC proposed to construct a new building. But again, it came under fire from the opposition parties in the legislature and from the OAMR.[16] In February 1978, in the face of massive opposition to the Etobicoke facility, Keith Norton who had taken over as Minister of Community and Social Services from James Taylor on February 3, 1977, vetoed the proposal and announced instead that ten to fifteen group homes each housing about eight severely or profoundly retarded people would be established throughout Etobicoke. A core residence and headquarters for thirty to forty people would be built on the original site, located near the intersection of two major highways and across from a racetrack. The Etobicoke development was to be a Schedule I facility, that is, it would be directly funded and administered by the government, a departure from the previous practice of making similar institutions Schedule II facilities, that is, funded by the government but administered by an independent community board. Eventually in the face of opposition from the OAMR and MTAMR this project was cancelled.

In his 1971 report, Walter Williston had levelled a sixteen-point indictment at the large institutions, predicting that they would play only a residual role in mental retardation policy in the future. However, the large facilities fought back against all attempts to undermine their role. In 1978, the *Globe and Mail* reported that: "The Ontario Public Service Em-

ployees Union says it intends to stir up latent public hostility to group homes in an attempt to undermine provincial efforts to move people out of institutions and into the community."[17] By the spring of 1978 the OPSEU News was publishing letters concerning the lack of community facilities available to discharged mentally ill and mentally retarded people. And in August, 1980 the union published a 103-page attack on the defects of the deinstitutionalization-normalization program. At this point the union argued that: "It would appear that not all patients respond equally well to community-based care. . . These types of patients require treatment in provincial hospitals. . . To deinstitutionalize any further would seriously jeopardize the well-being of patients."[18]

In addition to the unions, the bureaucrats associated with the facilities also resisted attempts to undermine the large facilities by establishing new programs and services. By 1979 the Ministry itself had come to the defense of the large institutions. A 1979 COMSOC policy paper observed: "Deinstitutionalization is primarily a negative concept which tends to focus on the real and imagined failures of facilities and deflects interest from potential future deconcentration and redeployment of the considerable resource talent currently based in provincial facilities."[19] Thus, in 1980 the Facilities Services Division of COMSOC listed 14 specific programs or services provided to mentally retarded people by the large institutions.[20] Moreover, a Community Services Division was established in all Schedule I facilities to "identify and coordinate all community services for the mentally retarded."

As one respondent in COMSOC put it, "the Schedule I facilities reacted in an extraordinarily creative way to the deinstitutionalization thrust. By 1980 we had to turn back requests from the facilities anxious to establish a variety of services and programs in the community from group homes to sheltered workshops."[21]

While the facilities were fighting a defensive battle, people associated with the community development thrust had their own problems. In their favour was the ideological shift from policies favouring the large institutions, to policies favouring community development. Since words and ideas are weapons in the struggle over policy, those supporting community had a vast armoury of terms at their disposal including "normalization," "community integration," generic services," "normal living," etc. But against them was the fact that they were few in number in the Ministry. In 1974 there were approximately seventy-six people working in community development in COMSOC or in the field as opposed to the more than 7,000 employees in the various facilities, plus the civil servants in COMSOC or attached to the Facilities Division in the field. Although they did have the support of the OAMR, they laboured under the handicap of having to create community support structures from scratch while those in the Facilities Division were dealing with structures which were decades and in the case of Orillia, more than a century old. The community development thrust was also hindered not only by a lack of

coordination with the Facilities Division, but by conflict over the level of funding provided to the local associations for group homes, sheltered workshops, day nurseries and other services, as well as by difficulties in getting the district working groups to operate as originally planned.

By 1976, however, some of the conflict was mitigated by the departure of two key figures in COMSOC — David MacCoy and Dr. Donald Zarfas. MacCoy left government to take up a consulting post, and Dr. Zarfas to return to the Faculty of Medicine at the University of Western Ontario in London. And in February 1978, the Deputy Minister Dorothea Crittenden also left to take another position in the civil service. The major effect of these changes was to reduce somewhat the personal friction and conflict that had plagued the Ministry from 1974. But another result was that the large institutions no longer felt that the community development program was a direct threat to their continued existence. From approximately 1976/77 on it became clear that the large insitutions would continue to play a major role in mental retardation policy and that COMSOC would move slowly and cautiously in elaborating community development policies.

The Progressive Conservative Model of Social Policy — a Begrudged Safety Net

In accordance with the government's policy of requiring families and voluntary organizations to contribute to the cost of residential services and sheltered workshops, the financing of these services has always been on a shared basis. Over the years the balance of government versus private funding had shifted, particularly with regard to sheltered workshops, but successive COMSOC Ministers from René Brunelle to James Taylor to Keith Norton reiterated their belief that having families or voluntary organizations contribute to the services for retarded people was of great importance in maintaining standards and morale. For example, when, on June 13, 1974, Liberal MPP B. Newman echoed a request from the local association in Windsor that capital grants for sheltered workshops be increased to 100 percent, the Minister, René Brunelle replied: "I doubt very much...that we will raise it to 100 percent, because we do believe that when there is community local involvement, that it makes for a much better program. Once government funds activities at 100 percent we remove some of that local involvement."[22] An additional argument for parental contributions was put forward by Brunelle a few days later: "I would say that the issue that parents felt was most important when talking about the concept of paying for services was really that there be service available, and that there needed to be new services developed and they would be very pleased to pay; because if they were paying then they could more easily criticize what was going on."[23]

At this point it is important to go into some detail about two models of social policy that have been the frequent (if implicit) guides to government action: the residual and institutional models. Although they have

been mentioned in the preceding chapters, the new element here is a brief statement of their relative merit and demerits, for a close reading of government documents and interviews with participants in the policy process in Ontario demonstrates that many politicians and civil servants had a highly sophisticated understanding of the various approaches to mental retardation policy, and that this influenced decision-making.

At the most general level, the distinction between the two models can best be understood by looking briefly at the different objectives, and at funding and administrative structures.

The residual model refers to social policies which come into play only after the family or private structures have broken down or failed to operate. It is a safety net concept of social policy. Residual social services are intended to supplement or correct the deficiencies of the private market system, not to replace them. The assumption in this model is that individuals should first seek help from their own family, or from other non-governmental bodies. Only after these alternatives have been exhausted should government step in to help those who have no other place to turn. In this model, social policy is intended to assist people to re-enter society. It provides a net to help those who fall out of the system, but it is not intended to provide a permanent source of support except to an assumedly tiny minority of people who are completely unable to help themselves.

In the residual model, government should provide only part of the funding necessary for the social services while the individual client, his family or voluntary organizations are usually expected to make some financial contribution. The client is also expected to pass an income or needs test before qualifying for the social service.

By contrast the institutional model is based on the assumption that in advanced industrial societies the private market system will always be unable to provide for some basic social needs and that it is government's obligation to provide for those needs as a matter of justice and right. T.H. Marshall has argued that citizenship in modern society not only establishes individual claims to political rights, but to social rights as well, and he sees the extension of institutional social services as fulfilling government's obligations in this area. Thus, in the institutional model, social policy services are an integral part of the system, not a grudging response to its deficiences. As such, social policies are expected to provide the best and most equitable service possible. In the institutional model, social policies are a permanent and valued part of the social system, they are one of the criteria by which people are asked to judge the qualities of the society. In the institutional model, funding and administration are provided by government, for although the administration may be organized on a centralized or decentralized basis, uniformity of service provision is an important goal.

Obviously, few social policies fall squarely within one or another of these models; they are usually mixtures of both. Generally speaking,

however, examples of residual social policies might be income-tested welfare or unemployment schemes, private hospital insurance plans with some government participation, or any shared-cost scheme between the private and public sectors. Examples of institutional social policies are universal health care systems, family allowances, child benefit grants, or government funded and administered housing for the elderly.

Since 1945 it has become quite clear that each model has both inherent advantages and disadvantages. Too often in the literature on the welfare state and on the various social policies which compose it, the relative merits of one model are vaunted and its disadvantages discounted. The fact remains that in the real world of policy, practitioners know that it is often difficult to choose only the best features of a particular model and to avoid its defects. Their best hope is to achieve at least some of their intended objectives. Keeping this in mind, the following discussion refers to the relative merits of the two models as manifested in two different approaches to mental retardation policy.

The proponents of the residual safety net model argue that it has the following advantages:

- The government saves money because the community shares in financing.
- Cost-sharing helps keep expenses down since users have to contribute to rising costs from their own pockets. This makes for increased economic efficiency and responsibility.
- The participation of local voluntary organizations means that those who best understand the needs of retarded persons play a direct role in delivering services.
- Voluntary organizations are usually more flexible and innovative than government bureaucracies.[24]
- Participation in the actual delivery of services gives voluntary associations a more realistic view of the political process than if they played an exclusively advocacy or critical role on the sidelines.
- Because workers in voluntary associations have positive feelings about mentally retarded people, the possibility of stigma is reduced.
- By charging a user fee government gives clients the feeling that they have a stake in the system. This means government has to be alert and responsive to the needs of its clientele.

Opponents of the residual model argue that it has the following disadvantages:

- Voluntary organizations are constantly forced to raise money to meet their share of costs. This absorbs an enormous amount of time and energy and eventually alienates the larger community which may become tired of the constant appeal for funds.
- Uneven funding and uneven provision of services often result because

of wide variations in the skill, ability and energy of volunteers.
- There is always the danger that voluntary associations may be co-opted by government and become reluctant to criticize for fear that public funds will be cut off.
- Despite the participation of voluntary organizations in decision-making, the real decisions are taken by government bureaucrats.
- The ideological assumptions behind the residual model mean that government provides the service only reluctantly, and that no attempt is made to raise the level of government services to that provided by the private sector. This necessarily has a deleterious effect on the quality of government-supported services and may also impose stigma on the clients.

The proponents of the institutional system claim the following advantages:

- "Priorities are ordered and resources are allocated by reference to criteria of need which are based on the welfare ethics of a social market in which the hallmark of good citizenship is the unilateral transfer from one person or group to another. The unilateral transfer is the epitome of social altruism."[25]
- Services are provided in a uniform fashion since the government is responsible for correcting geographical or social disparities.
- Unlike the residual model which often relies on untrained volunteers, only professionals staff services in the institutional model.
- Rather than individuals or organizations being co-opted, in the institutional system there is an absolute right to discuss and criticize government performance. Absent is the subtle moral pressure that exists in the residual system where citizens are made to feel that social policy is a reluctant concession forced from government and that criticism risks undermining the already tenuous support that exists for social policy.
- In the institutional model the objectives of social policy are to match or even exceed the level of quality of equivalent services in the private sector.

Opponents of the institutional model argue as follows:

- An ideological commitment to the provision of social policy services by government can lead to ever-increasing, and in the end, intolerable demands being made on the public purse. Because there is no incentive to economize, citizens and clients often overburden free services with trivial or unnecessary demands.
- A government monopoly of funding and adminstration inevitably leads to the classic dysfunctions of bureaucracy: overmanning, indifference to clientele and to the public, lack of innovation and

resistance to change.
- Because advanced capitalist societies put a high value on services provided in the private market, those who must seek help from government risk stigma. Moreover, because there are no user charges, the clientele of government social services are in the morally equivalent position of someone who receives charity. This is demeaning and demoralizing.
- Although governments may formally commit themselves to providing social policy services as a matter of right, when economic difficulties occur, the first place government looks to make economies is in the social policy sector. Complete dependence on government funding and administration means that outside pressure groups or voluntary organizations are ignored by government when difficulties occur, since the real threat to government policy comes from the professionals who staff the services and the bureaucrats who manage them.

What is interesting about these two models is that each makes a virtue out of what the other sees as a defect. For example, while the proponents of the residual model claim that social services in the institutional model suffer from all the disadvantages of bureaucratization, the defenders of the institutional model refer to the professionalism of government employees. And while the proponents of the institutional model accuse residualists of accepting an unplanned, haphazard system based on the goodwill of volunteers, the residualists talk about the human qualities of an altruistic relationship between clients and volunteers. And both sides accuse the other of imposing stigma on clients and of inefficiencies in funding and cost control. Thus, it does not matter toward which model social policy tends, it will always be subject to a withering fire of criticism from the supporters of the less-favoured model, and this criticism will often be couched in the same terms by both sides.

In this context, we may now be better able to understand the background to former COMSOC Minister Keith Norton's explanation of the Progressive Conservative principles that underlay mental retardation policy.

Soon after being appointed Minister on February 3, 1977, Norton made a detailed presentation before the legislative social development committee in October 1977.

Norton began by listing six basic principles "which have continued to guide the development of social services in Ontario." They were: "first, strengthening and maintaining the family unit; second, promoting individual and family independence and self-reliance; third, assisting people in their own community; fourth, providing services to those in greatest need; fifth, continuing the cooperative partnership among those delivering services and sixth, making maximum use of the resources at our disposal."[26] These principles were restated without change by Norton every year he was Minister. In 1977 Norton elaborated on these principles. He

noted that families and individuals should try to "work out difficult problems themselves before looking to government for solutions," and he argued that governments should emphasize services to the family rather than "focusing on the individual and his or her needs in an isolation apart from that."

These principles describe what might be called a modified residualist or begrudged safety net approach. A closer look at Norton's statements will demonstrate why those terms have been chosen.

As Norton pointed out: "Our social environment is one in which families and individuals try to work out difficult problems for themselves before looking to government for solutions." In this version of the model, the role of government is to respond to the demands of families or voluntary organizations unable to handle social problems, but government is not expected to seek out people with problems, nor to supplant existing structures or organizations. Moreover, the first line of defense is the individual or the family. In keeping with the residual safety net approach, government only comes on the scene after other alternatives have failed.

Norton also noted that a second goal "of human services is to promote an individual and society sense of personal dignity. . . ."[27] Explicitly rejected here is the idea that those forced to rely on government assistance should be stigmatized. This is in opposition to the traditional practice in the residual model. In arguing that the object of providing services in the community is to enable people to remain in their own homes or communities, Norton was stating a principle which should be interpreted as neutral in reference to the residual-institutional dichotomy, for in both models it is entirely possible that a major objective would be to help people to remain in a friendly or familiar environment.

In stating that services should be made available to those in greatest need and that priority would be given to services to "individuals and families who lack the economic and emotional resources to help themselves," Norton advanced an argument which falls squarely within the residualist approach since eligibility for services would be means or incomes tested.

In elaborating on his fifth principle, Norton argued that sharing responsibility for programs between the provincial government and local governments, and private or volunteer agencies, made the latter more "knowledgeable" about the needs of their clients. Finally, Norton pointed out that keeping municipalities and volunteer organizations involved in policy made them more "cost-conscious." And, he warned: "May I remind the members that spending vast amounts of taxpayers' money on social programs is sometimes not a popular thing to do. I know there is a feeling that we spend too much on and care too much for so-called welfare bums."[28]

Integral to the residual approach is the assumption that imposing user fees necessarily leads to greater efficiency in the allocation and use of resources, for if clients must pay even a token fee for services, then they

will not use those services unnecessarily, nor abuse them once they have gained access. The further implication is that services provided on the basis of right and without user fees are inefficient since there is no incentive for users to seek alternate services, to decide whether their need is serious or frivolous before resorting to institutional services, nor to feel any sense of responsibility for the services once they have gained access. [29] And finally, Norton's warning about a public reaction against the social services is an implied threat that to argue for more funds, or for an institutional approach, might put the whole social service system at risk. This reflects the attitude of one who sees social services not as a right nor as a basic necessity in advanced industrial society, but as a concession wrested from the community at great political and financial expense and constantly at risk in a basically hostile environment.

Whatever one might think about this approach, it did lead to a number of problems in community development. From 1974 on, local associations constantly complained about insufficient funds to establish and maintain group homes, residences, or sheltered workshops. In the case of group homes, for example, the government provided 80 percent of capital costs up to a certain amount, and 80 percent of operating costs. Although civil servants attached to COMSOC maintained that only minimal amounts were required from the local associations, especially since the 20 percent operating expenses provided from private sources were supposed to come largely from the clients' Family Benefits payments, many local associations argued that it was extremely difficult to build and maintain high-quality group homes given the limited government funding. Moreover, some executive directors of local associations criticized the Ministry because staff salaries at the Schedule I and Schedule II institutions were usually larger than salaries for equivalent positions at group homes or residences. They blamed the difference directly on Ministry policies. Finally, the executive directors complained bitterly that they did not have enough money to hire the staff necessary to cope with the paperwork involved in negotiating with the Ministry and with the district working groups. The community development thrust was also hindered by the opposition of local ratepayers in various parts of the province to the establishment of group homes and residences. By 1980, only the City of Toronto, London, and a few smaller municipalities had changed their bylaws to allow the establishment of group homes. Elsewhere, local associations had to get permission from the municipality. The result has been that in some areas, ratepayer opposition has blocked the establishment of homes planned for three or four years. But the government refused to do more than use persuasion on the municipalities. On November 7, 1979, COMSOC Minister Keith Norton said: "I am becoming very impatient with some.... I am on the verge at this point of seeking the support of my colleagues to have this kind of, frankly, discriminatory zoning eliminated."[30] In April, 1981, however, the Minister of Housing, Claude Bennet, altered the Metro Toronto zon-

ing plan so as to permit the establishment of group homes throughout the Metro area. This immediately provoked an angry reaction from the Etobicoke council which threatened to take the matter to the Ontario Municipal Board for resolution.

There was also continuing criticism of inadequate funding of children's services, and particularly of the lack of residential accommodation for children. The major reason was that only adults of 18 years or over were eligible to receive FBA from the province. Since these funds were cost-shared under CAP, there was a clear incentive for the province to push ahead on establishing programs for adults, and less of an incentive for children's programs. According to a 1975 policy paper published by COMSOC, the reason for giving priority to adult services was because there were "constraints on financing children's services at present."[31] Since the average monthly fees for children's residences ranged between $180 and $200 per month, it was no surprise that by 1980 there were only 254 beds available in residences operated by local associations.

Quite clearly the availability (or lack thereof) of cost-shared federal funds, and the provincial commitment to a residual model of social policy had a major influence in ordering the priorities of mental retardation policy. One consequence of the decision to give lower priority to children's services was to encourage what has been previously referred to as the fob-bing-off process. Despite various policy statements from politicians and civil servants that user fees contributed to the rationality, efficiency and responsibility of the social services, one policy analyst found that those services funded 100 percent by government usually had more autonomy over deciding which clients they would serve and a better staff-client ratio than services which were not funded at the 100 percent level. "A common complaint from practitioners was that the services with the greatest resources had the widest freedom of choice on admissions and those with the least resources had much less choice. Children's Mental Health Centres with 100 percent funding, for example, were in the position of balancing their workload as they chose. The service with the least number of staff, i.e., Children's Boarding Homes had to accept children referred to them by Children's Aid Societies."[32] Another example of fob-bing-off occurred in Toronto where it was found that because parents could not get their mentally retarded children admitted to the Huronia Regional Centre because of the emphasis on de-institutionalization, and could not afford the monthly fees for residential facilities, they were forced to leave their children with the Toronto Children's Aid Society. A 1977 study found that whereas in 1970, 18.7 percent of children under CAS care in Toronto were "mentally retarded or slow learners," by 1977 that percentage had increased to 41 percent.[33]

By 1980, however, COMSOC decided to increase the level of subsidy for residential services for children from 80 to 97 percent. The difference was to be made up by the "service deliverer" with parents expected to contribute a certain percentage of their family allowance benefits, the

level to be determined on an income-tested basis.

In conformance with traditional Ministry practices and the residualist safety net ideology of the government, it was initially decided that the government should restrict its administrative role in community development to activating and coordinating local voluntary agencies, and local governments and services. The expectation was that mentally retarded people increasingly would be able to use the generic services of the community. "Every effort should be made to use community medical, dental, family support, educational, employment and recreational resources to meet the needs of mentally retarded people." Where specialized services were provided, the ultimate goal was "to develop appropriate generic resources in the community so that special programs and services can be discontinued."[34]

The district working group was established to assess existing community resources, help local associations to establish the necessary specialized services such as group homes or sheltered workshops, help voluntary agencies and local governments coordinate generic services for mentally retarded people and link these groups and organizations with the Ministry. Nineteen mental retardation coordinators were appointed by the Ministry to help perform these functions and to produce plans for the various districts. But here, too, the practice was not necessarily in conformance with the ideal.

One of the major problems encountered was the lack of incentive for local governments or voluntary organizations not directly involved with mentally retarded people to make existing services available to them. There were constant complaints over the years about the slow pace at which services were established and about the reluctance of some local communities to give mentally retarded people access to existing services. In addition, local associations sometimes faced enormous delays in getting their plans for providing services accepted by the Ministry. Two points of view were usually expressed. Ministry officials argued that many local association executives were unskilled or inexperienced in drafting such plans — one official mentioned the case of a local that presented its plan for a group residence written on a brown paper bag. But local associations contended that the Ministry was inefficient, often unduly skeptical of the association's ability to carry out its objectives, and always penurious in the allocation of funds. Here, too, the opposition parties in the Legislature began to criticize the government. According to NDP member Ross McClellan: "I know just how difficult it is for volunteers, like the volunteers in associations for the mentally retarded, to run programs to provide services when government fiddles around, and delays and procrastinates and gives contradictory policy assertions and changes its funding criteria and changes its administrative procedures with staggering regularity. The blight of the voluntary sector, quite frankly, is having to deal with the vagaries of government administration and government funding policies."[35] A year and a half later, McClellan

observed that the local associations "seem to be increasingly dispirited and demoralized."[36] In March, 1978, the OAMR claimed that: "Mental retardation working groups are frustrated in a variety of ways, but the overlying description might be termed 'an inability to make real, constructive and well coordinated decisions and plans for the region in which they function.'"

In 1977 there was a major reorganization within COMSOC, with the establishment of a separate children's services division. The result was that the district working groups no longer had responsibility for mentally retarded children, thus further undermining their authority.

Whatever one may think about the successes or failures of the government in establishing community services for mentally retarded people after 1974, few would claim that the community development program had met all its objectives. On March 10, 1977, Alan Gordon, Assistant Deputy Minister in COMSOC was quoted in the *Globe and Mail* as saying that the Ministry was revising its earlier goal of transferring half the residents of the large facilities to the community "in view of the realities we are facing." And COMSOC Minister Keith Norton was reported to say that there would have been more progress if there had been more money, "if projects were not delayed up to two years because of rezoning that must be done before homes for the retarded can be built in the community; if more community residents were receptive to the establishment for a home for the retarded in their neighbourhoods; if families of the retarded did not object to having their relatives living near them again." By 1978 Alan Gordon noted in a memo that almost 2,000 residents of the Schedule I and II facilities were ready to move into the community within one year, and a further 776 within two years but that "the community living thrust has not developed as rapidly as was expected, due to a variety of causes."[37]

One reason for the difficulties government encountered in its attempt to re-orient mental retardation policy toward community living programs is that in politics one can never expect to achieve one's first objectives since unexpected obstacles always arise. Those who had elaborated the new policy orientation in 1973/74 did not sufficiently take into account the resistance that would be encountered in the community to the establishment of further services for mentally retarded people, particularly group homes. They were also surprised at the vehement reaction against the community development program from the institution employees and staff, as well as local municipalities, and they completely underestimated the strength of the pro-facility forces within the Ministry. In addition, they were perhaps overly optimistic about what the injection of CAP funds would do for the financing of community development programs. And finally, they also overestimated the willingness of local communities to support the community development thrust as well as underestimating the complexities involved in trying to use the district working groups as an instrument of activation and coordination.

In some cases COMSOC met with, at best, grudging acceptance, and at worst, reluctance to support or even hostility towards COMSOC initiatives. Moreover, the fact that COMSOC retained ultimate control of funds and authority over the plans submitted from the nineteen mental retardation districts meant that local municipalities and voluntary organizations were put into a highly dependent position. By reserving ultimate funding and administrative decision-making powers for the Ministry at Queen's Park, COMSOC inevitably created the classic situation that arises where local offices — in this case the working groups — become alienated from or hostile to the central decision-making authority. This situation might have been alleviated if the local associations for the mentally retarded had been able to compensate for the one-sidedness of the relationship, if they had been given some independent decision-making or budgeting powers, or if there had been wider support for the community development thrust in the community. But this was not the case. At the same time, the district working groups were weakened from 1974 to 1977 by the fact that the Facilities Division seemed to be deliberately ignoring or even bypassing them, as in the case of the Goderich dispute, while in those districts where a large facility was present, there was either little coordination between the group and the facility, or the facility simply overwhelmed the group because of its enormous size and its direct links with the Ministry. It remains to be seen whether recent COMSOC reorganizations and decentralization of decision-making power over funds and administration to a regional level in children's services will compensate for the defects.

Mentally Retarded People in the Homes for Special Care

One final, major development in mental retardation policy occurred in 1980 with a joint announcement from the Ministries of Health, Education and COMSOC of a four-year, $29-million program of assessment and developmental training for mentally retarded people in the Homes for Special Care program.

Since its inception in 1964, this program had been a continuing source of discomfort for the government, ammunition for the opposition parties and of scandals for the media. After 1968, mentally retarded people had been transferred from both Schedule I and Schedule II facilities as well as from psychiatric facilities to the Homes for Special Care. By 1979, 2,174 residents in both the nursing home and residential home categories had a primary diagnosis of mental retardation.[38]

Yet in the spring of 1975 COMSOC clearly expected that mentally retarded people in the program would be transferred from Health to COMSOC.[39] The reason why the transfer never took place is not clear. One civil servant claimed that there was conflict between the two ministries over funding, that Health was reluctant to turn the program over to COMSOC because it was expected to lose funds thereby, while the fact that mentally retarded people were mixed in with people from psychiatric and

other facilities complicated the administrative aspects of such a transfer. Another curious aspect of the situation is that in his Peterborough commitment of 1974, Premier Davis had promised that CAP funds obtained for mentally retarded people would be used for mental retardation policy. Although this appears to have been the case as regards those mentally retarded adults who were transferred from Health to the jurisdiction of COMSOC on April 1, 1974, there is no evidence that mentally retarded people who were receiving family benefits payments as residents of the Homes for Special Care benefited in any way from the injection of CAP funds.

Thus, despite the fact that the primarily custodial role of the Homes for Special Care had become transparently clear, for sixteen years the government did absolutely nothing to improve conditions there. When the OAMR began to prod the government the usual response from the Ministry of Health was to ask for community volunteers to visit the homes. As a 1974 brochure published by the Ministry of Health put it: "Individuals and groups from the community should be encouraged to visit the home to help with social and recreational activities. The Canadian Mental Health Association, the Ontario Association for the Mentally Retarded and a number of other organizations are all interested in helping."[40] In 1975, the OAMR calculated that the average caseload of the Ministry of Health workers assigned responsibility for the homes was 265 residents. The OAMR recommended that the program be transferred from the Ministry of Health to COMSOC and that money be made available for programming to assess and then provide appropriate treatment or activities for mentally retarded residents in the homes. In February 1976, the *Globe and Mail* ran a series of articles criticizing the program. As the reporter put it: "In many cases all over Ontario, these discharged people continue to live in the backwaters of the community, isolated in rural homes and largely forgotten by their families and the rest of society. Their basic needs — for shelter, food and clothing — are met by the ministry. Their psychiatric, social and recreational needs are not."[41]

At the same time as these articles were appearing in the *Globe and Mail,* a Task Force established by the Ministry of Health was holding meetings to discuss the Homes for Special Care program. Although a representative from the Canadian Mental Health Association was appointed to the Task Force, there was no one from the OAMR. The findings of the Task Force reveal why the government was reluctant to make changes.

Although COMSOC had accepted the notion that wherever possible mentally retarded people should be transferred from large institutions to smaller community settings, especially group residences, in 1976, 32 percent of the residents of the Homes for Special Care were in homes which accommodated twelve or more people. The reason was because "it is easier to obtain large homes primarily because they offer a better financial investment to the owner...political repercussions would be in-

evitable if 114 residential homes which presently have a licensed capacity of more than five were phased out."[42] Thus, the Task Force recommended that "no formalized programming was necessary in the small residential homes because residents were an integral part of the family and as such their integration into the community simply through the activities surrounding day to day living was more readily achieved."[43] But the *Globe and Mail* reporter investigating the homes stated that "activities in the smaller residential homes were haphazard at best and non-existent in many."[44] Moreover, given the large caseload of the Ministry workers and the fact that the "hosts/hostesses" of the homes were not required to have any particular level of formal education or to have undergone any specific training, whether or not the residents were offered programming was a matter of sheer luck. And although the hosts/hostesses of the Homes for Special Care were allowed to dispense drugs to their residents according to medical instructions, the Task Force recommended no changes in this procedure.

Thus, while COMSOC was attempting to remedy some of the major deficiencies in mental retardation policy, the Ministry of Health did absolutely nothing to correct what can only be described as a scandalous situation. But the OAMR continued to pressure the Ministry and the government. In 1979 a number of parents and ex-staff members of the Good Samaritan Home in Alliston, Ontario submitted a detailed brief to Minister of Health Dennis R. Timbrell exposing cases of severe malnutrition and death apparently brought on by poor conditions at the home.[45]

In August 1979, Rick Miles of the OAMR staff submitted to the OAMR a detailed history of the Homes for Special Care program as well as a series of suggestions about the best strategy for getting the government to make improvements.[46] In that same month the government established another interministerial task force. But by this time the OAMR had lost patience. By December 1979 it had mapped out a strategy to force the Ministry of Health to improve the program. Beginning with a request to local associations to send any "horror" stories about the Homes for Special Care to the OAMR head office, the idea behind the strategy was to escalate pressure on the Ministry until, if no changes were forthcoming, a public press conference would be held where the OAMR case would be presented.[47]

By this time as well Professor Cyril Greenland of McMaster University had discovered that there were 325 children in the Homes for Special Care and that only twenty of them were involved in educational programs.[48] Since the public is usually very sensitive to stories of child abuse or neglect, the OAMR now had a powerful publicity weapon at hand, and it began to deluge the government and the press with complaints about the lack of government action. Finally, on March 6, 1980, the Ministers of Health, Education and Community and Social Services announced that the interministerial task force had completed its work and that it had recommended that a new program of assessment and activity

be established for mentally retarded people, including children, in the Homes for Special Care. But even then nothing explicit was said about developmental training for the mentally ill residents and patients; rather, the focus was on mentally retarded people. "All mentally retarded clients who can benefit," the statement read, "will receive developmental training while all other clients will receive program alternatives appropriate to their needs."[49] Moreover, in line with the government's residual model of policy, no fundamental changes were to be made in a system whereby private owners operate nursing and residential homes for profit. Nor were any changes to be made in the qualifications demanded of the operators.

The government did establish a "provincial liaison group" consisting of representatives from the OAMR and the Ontario Nursing Homes Association. At the same time "local advisory committees" were established with representation from the Homes for Special Care, nursing homes, and staff from COMSOC, Health, Education and the mental retardation working groups. But as had been the practice in the past, the government gave these bodies only advisory and coordinating functions.

For those inclined to argue that the government always tries to co-opt potential critics, the membership and powers of these bodies could not provide a better illustration of their thesis.

But why was this reform so long in coming? One reason is that the Ministry of Health has traditionally been extremely reluctant to make major changes in mental retardation policy. Its main concern has always been with active treatment hospitals, and the main pressure group it has responded to has been the Ontario Medical Association. It was only when mental retardation policy was switched to COMSOC in 1974 that genuine reforms were made. Moreover, according to the Ministry of Health the average age of the residents in the Homes for Special Care in 1975 was between sixty and sixty-five.[50] Whereas many mentally retarded adults and even more mentally retarded children in the province had extremely vocal parents or relatives to speak for them during the 1960's and 1970's, most of the elderly residents in the Homes for Special Care had only voluntary groups such as the OAMR or Mental Health Ontario as their spokesmen. The pressure of these two groups was insufficient to force the government toward reform. The PC's were criticized for this passive attitude in the Legislature by NDP critic Elie Martel on June 11, 1974 in discussing the problems of the physically handicapped. "You can't wait for some voluntary group to come along and establish it [special workshops]. You wait for some organization like the mentally retarded to come along and pick up the pieces and do the nucleus of the work. You are going to partially fund it — and that is great. But who does it for this other group unless you are going to do it as a government?... Who is going to do it for these people when there are no associations involved?... I suspect part of the problem — the key problem of course, is that there is no one out to bat for this group. They do not have

an association or someone representing them."[51]

Only after years of pressure, and after a series of scandals which were given wide press coverage did the Ministry of Health and COMSOC finally undertake a program of reform. As in the past, only after an outside pressure group took the initiatve did the government agree to reform an egregiously unjust policy. But this does not mean the government will not carry through its promises, for as we have seen in the case of COMSOC after 1974, once a reformist constituency is created within a bureaucracy, it tends to take on a life of its own and to fight energetically for its own goals. The future of the program will depend on the resistance encountered within the various ministries, from the operators of the Homes for Special Care, and particularly, from a government which may look for future economies in programs such as the one just established.

The OAMR

The evolution of mental retardation policy after 1974 was influenced not only by the internal conflicts and divisions within COMSOC and by the problems inherent in the funding and administrative methods chosen for the establishment of community services, but also by relations between COMSOC and the OAMR.

Unquestionably the OAMR played a crucial role in helping to re-orient policy in the period from the Williston Report in 1971 to the transfer of mental retardation services from Health to COMSOC in April 1974. And for a short time after that, relations between the OAMR and the Ministry were quite good. Civil servants from COMSOC observed that OAMR officials were frequently consulted on policy, and particularly on the community development thrust, that they often sat together with Ministry officials helping to plan policy, and that personal relations between the senior civil servants and the OAMR staff were excellent. But after 1976, the relationship began to cool down.

One of the reasons was that although the OAMR had won the battle of words and ideas, symbolized by the fact that the Williston Report reflected OAMR thinking, it was much more difficult to get those ideas translated into policy. Whereas before 1974 the large insitutions were a popular target for criticism, and the scandals that occurred there amenable to dramatization in the press and legislature, problems arising with the community development thrust were more complicated. It was much easier to be "against" the big institutions and "for" community development before 1974. It was much more difficult to marshal support when the issue revolved around the question of whether the government was moving too slowly or too quickly in establishing the community development program. Moreover, while Dr. Donald Zarfas had been a major and powerful OAMR ally in the Ministry of Health where he was responsible for mental retardation policy in COMSOC, after 1974 he was just one, and it turned out, the weakest, of three partners responsible for facilities, community development and program analysis. Now the OAMR had to

exert pressure on different people with different and, sometimes competing philosophies about mental retardation policy. And when Dr. Zarfas left the Ministry in 1976, the OAMR lost one of its best contacts in the civil service.

By 1976, relations between the OAMR and COMSOC had reached a low point under Minister James Taylor. Unfortunately Taylor had become Minister at a time when the government had announced a financial restraint program restricting the growth in Ministry funding to 5.5 percent. At the April 22, 1976 annual meeting of the OAMR, Taylor noted: "The only exception to these restrictions is the mental retardation area in which new community program proposals will be evaluated in light of the restraint program. Lest anyone misinterprets this statement to be a carte blanche for new construction and new programming — it is not." At the meeting Taylor also defended himself against criticism over the Timmins and Goderich issue and Ministry relations with the district working groups. But the response from some OAMR members was hostile. Elva Telfer, at that time a director of the OAMR, argued that the Ministry's attempt to establish resource centres may have been "the product of back-room wheeling and dealing." And she suggested that the Ministry was "unilaterally changing what this Association thought was clear public policy." She accused senior civil servants of deliberately trying to undermine the community development thrust. Other OAMR members joined in the criticism and even Walter Williston, an invited guest of the OAMR at the meeting, noted that "there is a great deal left to be done." Taylor replied sarcastically that he "appreciated hearing those remarks and how supportive they are in every way," and he warned that "you can't press buttons and make [the institutions] disappear."[52] The immediate result of this confrontation was to further widen the growing split between COMSOC and the OAMR over the shape and pace of the community development program. Senior civil servant Alan Gordon was quoted in the *Globe and Mail* as saying that: "Our relations with the [OAMR] have been somewhat strained in a number of incidents in the last year." And he admitted that in 1977/78 COMSOC provided $66,000 to the OAMR as an administrative grant, rather than the $70,000 requested.[53] However, the OAMR argued that the cut had really been $310,000. The difference derived from the fact that in 1977 COMSOC decided to terminate an agreement whereby they had purchased services from the OAMR for over $300,000 during the previous two years. The OAMR was referring to this agreement, while Gordon was referring only to COMSOC funding of certain OAMR administrative costs.[54]

At this time as well, the OAMR was engaged in soul-searching concerning its organization, goals and relations with government. In April 1976, the Board of Directors had commissioned a study on the "Future Role of OAMR Regarding Advocacy and Service Delivery," later known as the Role Study. Among the authors was David MacCoy who had recently resigned as the director of community services development in

COMSOC. The question was whether the local associations should continue to play a major role as service providers for the government, or whether the locals should move toward an advocacy or monitoring role. The authors of the Report argued that, historically, it was never the intention of the OAMR to move into a position of a major service provider, and that organizationally it would be extremely difficult for the OAMR to achieve its stated objective of ensuring that mentally retarded people could "share in all elements of living in the community and have the opportunity to participate effectively" if local associations continued to provide separate services for retarded people. The Report was particularly critical of the fact that local associations were in danger of being co-opted by the government, since their dependent role made it difficult for them to criticize the government or advocate new programs. In making their case for a reduced service role and a vastly increased emphasis on an advocacy role, the authors referred to work by Rosemary Dybwad of the Heller School of Social Welfare at Brandeis University, and Wolf Wolfensberger on the usual evolution of voluntary associations.[55] Rosemary Dybwad saw voluntary organizations moving through a number of stages from providing services to monitoring services; from focusing on the needs of mentally retarded people to concern with the needs of all handicapped people; from organizations consisting of parents to organizations including handicapped people themselves; from organizations providing services which duplicated existing services or which might as easily be provided by government to organizations providing services which could not be provided elsewhere.

And the authors of the Role Study mentioned Wolf Wolfensberger's argument that mental retardation organizations naturally progressed through a series of stages from one where private voluntary organizations provided services to one where there was primarily public funding and organization; from a situation where the plight of handicapped people was improved through bureaucratic legislation to one where it was improved through legislated rights; from a situation where services to handicapped persons were specialized to one where they merged with generic services; from remediation toward prevention and from administration at the local level to administration at the national level, or back again, but with increasingly complex bureaucratic linkages.[56]

What is interesting about this line of argument is the subtle movement from "ought" to "is." The authors begin with certain preconceived ideas about the best direction for voluntary organizations and then suggest that history is moving in that direction. But there is no inevitability in history. As the Role Study points out, previous OAMR policy studies had suggested that local associations abandon their service delivery role and move toward an advocacy position, but with little effect. And ironically, although the main recommendations of the 1977 Role Study were adopted at the OAMR annual meeting, by 1980 the local associations were as immured in the delivery of services as ever, and there were even

requests from some locals that the 1977 vote be disavowed.

Why have the local associations resisted abandoning their role as service providers? The reasons advanced were exactly the same as those marshalled in support for the residual model of social policy and against the institutional model: local associations are closer to mentally retarded people and have a more intimate understanding of their needs than government employees; bureaucracies become rigid and unresponsive to local needs; the government has only limited funds; and, if local associations pulled out of service delivery, they would have no role to play and would lose membership and support.

But the authors of the Role Study as well as those opposed to the service delivery model argued that "the development of service empires, including acquisition of real estate, makes it difficult to relinquish ownership but also to respond to pressure for needed changes."[57] They also argued that locals had not been able to develop comprehensive services and had been forced to concentrate on too narrow a range of services, mainly residences and workshops; that there had been increasing bureaucratization of the locals as they grew in size and hired staff; that dependence on government funding weakened the desire to criticize government; that there had been goal displacement as locals became increasingly concerned with perpetuating their own organization rather than working for the benefit of retarded people; involvement in services tarnished the altruistic image that locals try to project, since they were perpetually scrabbling for new resources from the government or the public; that the provision of special services to the retarded through locals was stigmatizing and finally, that since the logical outcome of normalization was that mentally retarded people should have access to services used by non-retarded people as well, local associations would inevitably find themselves in the awkward position of being asked to open their specialized services to non-retarded people.

The difficulty with the latter set of arguments is that members of locals either disagree with them, or see little alternative to their current role as service providers. When questioned about the argument that they cannot, on the one hand, ask the government for funds and still play a critical role, the response of many locals was to ask why government should pay attention to locals which had no direct role in providing services. Contrary to the authors of the Role Study, therefore, they see their influence over the government as a direct function of their role as service providers. Without that function, they argue, their voice would be drowned in the general clamour from interest groups each making their individual demands on government. To the argument that they provide too narrow and specialized a range of services, locals respond that the community is basically disinterested in providing services for mentally retarded people, that to expect retarded people to rely increasingly on generic services is an illusion and that if the locals did pull out of their service role, mentally retarded people would be increasingly isolated in an indifferent society.

As for accusations of bureaucratization and goal displacement, the response is that one cannot have organization without some degree of bureaucratization, that the primary goal still remains to enhance the interests of mentally retarded people, and that turning services over to government would lead to an even worse degree of rigidity and hierarchy. Finally, to the argument that voluntary organizations for mentally retarded persons must inevitably concern themselves with all handicapped people, the response is that it would be unrealistic to expect parents of mentally retarded people to continue to work for the local associations if their energies were diverted into a general struggle for all handicapped persons, and that it is just because the locals are specifically concerned with mentally retarded people that they remain active.

If we return to our initial distinction between the residualist and institutional models of social policy, and narrow their meanings so that the residual model refers to a social policy whereby the government plays a partnership role with voluntary organizations in funding and administering services, and the institutional model refers to a social policy whereby the government provides full funding and administration, and if we further stipulate that the objective of both models is to provide the best possible level of unstigmatized service then it appears that within the OAMR and the local associations there are basically four sets of opinions about the proper policy to follow.

First, there are the "reluctant residualists," that is, people who would like the associations to move toward an advocacy role but feel that they have no choice but to continue providing services since they are skeptical that government would take up services vacated by the local associations. Second, there are the "positive residualists," those who are quite happy with the current relationship between government and the local associations and who feel that the proper role of government is not to become too deeply involved in funding and administering services. Third, the "reluctant institutionalists" prefer that the current relationship continue but feel that only if the government moves in and provides services to retarded people in the same way as public education is provided to the young can the defects of the current system be corrected. Fourth, the "positive institutionalists" (Dybwad, Wolfensberger and the authors of the Role Study, for example) feel that it is the proper role of government to provide services to the retarded as a matter of right, and at the same level as services are provided to other members of the public.

It is the continuing disagreement among these four groups that accounts for some of the dissension within the OAMR and helps to explain the current malaise that grips the locals. The situation is exacerbated by the fact that those residualists who support the service-providing role of the locals tend to be located outside Toronto in the smaller local associations, while those who support the institutional model are located mainly at the OAMR or at the National Institute on Mental Retardation in Toronto.

The future of the OAMR and the local associations looks even cloudier when viewed from another perspective.

Pressure groups play an extremely important role in the political process. As policy initiators they can affect the political agenda by raising issues or focussing public attention on particular, but neglected issues. Most important, powerful pressure groups can affect the kinds of judgments we make about issues by influencing societal norms and values as well as the vocabulary we use in discussing problems. Powerful pressure groups may even be consulted on a formal or informal basis by government on issues of concern to that group. Such was the case with the OAMR and the Department of Health during the late 1960's and with the OAMR and COMSOC after 1974. But if one distinguishes between consultation as referring to a relationship whereby government asks pressure groups for their advice and approval on particular policy matters, and negotiation as a situation whereby the pressure group may exercise a veto over government policy, then it is quite clear the government frequently consulted but never negotiated with the OAMR. Nor did the OAMR ever reach a position where it participated formally with civil servants on regulatory bodies with decision- or rule-making powers. Indeed, the OAMR seems to have lost ground since 1974.

One of the major tools in a pressure group's arsenal is its research and fact-finding capability, for this affects values, norms and vocabulary. But since 1974 COMSOC has established at least four separate offices devoted to program or policy analysis. Although it is arguable as to whether this increased research capabililty exceeds the combined resources of both the OAMR and the National Institute on Mental Retardation, it is no accident that the current concerns and trends in mental retardation policy such as new modalities of children's and adults' services, and evaluating programs on the basis of client satisfaction have all been put forward by COMSOC and are less clearly associated with any initiative from the OAMR.

The policy consultation role filled by the OAMR from the late 1960's to early 1970's also seems to have diminished. Except for their membership in the district working groups, members of the OAMR do not participate in any formal sense in the process of policy-making, while informal contacts between COMSOC and the OAMR have decreased. Civil servants in COMSOC do not feel it is necessary to account to the OAMR for mental retardation policy, nor do they feel that the OAMR's support is a necessary precondition for implementing policy. There have also been changes in the personnel who staff the upper levels of COMSOC. Whereas prior to 1976 many of the senior civil servants who dealt with mental retardation policy came from the outside and were primarily interested in programs and policy, as was the case with Dr. Zarfas and David MacCoy, after that date there was an increasing tendency to appoint economy-minded career civil servants from within the Ontario bureaucracy, particularly from Management Board.

For all these reasons, then, the OAMR seems to have lost influence since 1976.

One apparent exception to this statement concerns the recent reform of the Homes for Special Care program, but even in this case the OAMR was not invited to participate in the interministerial committee of 1979 which formulated the reform. And while the OAMR had been clamouring for years for changes, the actual initiative as well as the final determination of the new policy seems to have come primarily from COMSOC.

One illustration of the tentative relationship that exists between the OAMR and COMSOC comes from a strategy paper on the Homes for Special Care program written by an OAMR staff member in August, 1979.[58] In this paper the author discusses three possible strategies the OAMR could use to force a reform in the program: a low, medium or high profile strategy. Of the three he advocates the low to medium profile strategy whereby the OAMR would meet with government officials, submit written briefs to officials as well as to legislative committees, and help newspapers prepare articles on the Homes for Special Care. But, the author warns, "the media coverage should concentrate on positive aspects of a retarded person's life and not dwell on the problems of the Homes for Special Care as they exist." Indeed, the basic theme of this approach is that the OAMR not antagonize government by going through opposition members in the Legislature, trying to rouse the public or engaging in confrontation tactics. "This strategy," the author warns, "can be highly dangerous to an organization like the OAMR as it can weaken relationships with Government Ministries for a lengthy period of time."[59]

Three conclusions can be drawn from this paper about how the OAMR currently views its relationship with government. First, the OAMR is highly protective of its informal links with the bureaucracy. This caution derives from the fear that going outside the bureaucracy might damage these relations. In this sense the OAMR is hostage to the civil service, for if its proposals are rejected then the OAMR risks losing whatever influence it has if it is forced to seek help from the opposition parties or the public. Second, there is the implication that the OAMR is on the outside looking in — that is, there are currently no formal structural links between COMSOC or the other ministries and the OAMR. Thus the OAMR can only hope to be consulted on policy issues, but it cannot compel the Ministry to do so. Third, the fact that an upbeat style of publicizing the Homes for Special Care issue is preferred, implies skepticism about the effect a public outcry would have on government policy.

Despite the fact that the government finally did accede to requests for changes in the program, the future direction and influence of the OAMR remains in doubt. It is unlikely it can regain its lost influence unless there is either a major value change in society regarding mentally retarded people, or an egregious scandal once again focusses attention on their plight.

At a more general level, the fact that so many mentally retarded people are on Family Benefits (13,510 in 1977/78, or 12 percent of the total number of people on FBA in Ontario) means that one can no longer speak of mental retardation policy in isolation from the more general issue of social welfare. Moreover, questions are already being asked about the fact that mentally retarded people seem to get extra benefits through the subsidies to group homes, sheltered workshops, etc., that are not necessarily provided to other groups on welfare. Perhaps this is the greatest irony of all. For years people fought against the idea that mental retardation was a health problem and not a social problem. The victory of 1974 was symbolized by moving mentally retarded people out from under the jurisdiction of the Ministry of Health into the Ministry of Community and Social Services. In many ways this was a remarkable victory for the OAMR and for their supporters in government, and certainly the Progressive Conservatives should be given full credit for the re-orientation of policy toward de-institutionalization and community care. But instead of fighting against a medical (or more accurately, an asylum model of care), the supporters of mentally retarded people now have to contend with a social welfare model. In a province run by a party and a government whose concern for the social services has been lukewarm at best, it is questionable whether the 1974 switch was a victory or rather an exchange of one set of problems for another.

Summary

From 1970 to 1980, the shape of mental retardation policy began to change. After years of discussion the government finally began to transfer large numbers of mentally retarded people out of large institutions into community residences. And although they have not been discussed here, a wide variety of programs for mentally retarded people were expanded and improved: sheltered workshops, family relief facilities, counselling and prevention programs, protective service workers, etc. The government also expanded financial aid for parents of severely handicapped children by providing them with $175.00 per month to help cover the costs of home care.

Mental retardation policy emerged out of a complex political process which included a number of factors, each of varying degrees of influence and importance. The political actors included the OAMR and its local associations, the senior bureaucrats in the Ministries of Health and Community and Social Services attached to the large institutions, the various Ministers of the day, opposition MPP's and the press. Ideas and ideologies set the parameters of action within which the major political actors formulated and implemented policy. Finally, pre-existing policy was an important influence on contemporary policy.

If we leave aside the influence of ideas and ideologies, then mental retardation policy in Ontario emerged from a political process where the OAMR and senior civil servants in Health and later COMSOC played

key roles. It might be helpful for an understanding of this process if we tried to place what actually happened within an analytical context.

There are a variety of ways to describe the relationship between bureaucracies and interest groups, but to illustrate the point three models are described: the corporate, differentiated and co-optative models.

In the corporate model, interest groups not only establish close links with bureaucracies, ultimately they become incorporated into the state apparatus. In a corporate state, groups, not individuals are the juridical basis of sovereignty and this is reflected in the fact that groups or corporate bodies are represented as such in the governing bodies of the nation. But without going as far as this, one might call a corporate relationship one where interest group representatives sit side by side with civil servants on semi-independent regulatory bodies which have rule-making powers. Moreover, the relationship is one of equals, that is, the government cannot ride roughshod over a corporate interest group but rather must negotiate with it over policy that is of concern to the interest group. Occasionally government may have to back down in the face of interest group opposition to a particular policy. One example of this in Ontario can be found in the relationship between the Ministry of Health and what Carolyn J. Tuohy calls the "core institutions" of medicine, namely the College of Physicians and Surgeons and the medical schools.[60]

In a differentiated relationship the line between bureaucracy and interest groups or voluntary organizations is sharply drawn. Interest groups can attempt to affect policy by influencing public opinion, wielding the voting power of their members as a weapon, or providing information to the press. But the bureaucracy does not place interest group members on semi-independent decision-making bodies or even on informal consultative bodies alongside civil servants. Until recently, an example of this was the relationship between the corrections bureaucracy and prisoners' interest groups. A more general example would be the relationship between peace groups and defense bureaucracies.

In a co-optative relationship the bureaucracy may occasionally consult interest groups, involve them in the process of policy formulation and implementation and even delegate certain service-providing roles to them. But the relationship is basically one between unequals, for the bureaucracy is the ultimate authority when it comes to deciding if and when it will deal with the interest group. In this relationship as well, the interest group is protective of its links with the bureaucracy and is constantly fearful that if it is too critical or too negative, the bureaucracy may retaliate.

Any one of these models may prevail depending upon the interest group, and the government department, ministry or agency being dealt with. However, it is possible to obtain some insight into the ideology of a government, or more accurately, of a ruling political party by establishing a profile of the varying relationships that exist between the bureaucracy and interest groups. For example, one might expect socialist governments to establish corporate-style relationships with trade unions or

other bodies representing the workers, and with social welfare interest groups, while one might expect a quite different pattern to emerge in the case of more business-oriented governments.

In the case of the Progressive Conservative party in Ontario, the government has been extremely wary of entering into any kind of corporate relationship with the OAMR. Some people have argued that the government has effectively co-opted the OAMR and the local associations by getting them to provide services to mentally retarded people without being given any formal reciprocal role in policy formulation. Moreover, when it became apparent during the late 1960's and early 1970's that the OAMR had established good personal relationships with officials in Health and COMSOC and that it was increasingly consulted by civil servants in the process of policy-making, a series of reorganizations in the Ministry, and changes in bureaucratic personnel effectively broke the OAMR's close links with COMSOC. The dramatic cut in COMSOC subsidies to the OAMR occasioned by the criticism directed against Minister James Taylor at the OAMR annual meeting in 1976 demonstrates that COMSOC officials felt no compunction at all about alienating this major interest group.[61]

Is it possible to generalize from the relationship between the government and the OAMR and to reach some conclusions about the Progressive Conservative ideology? To generalize beyond our model of a "begrudged safety net" might be risky, but some tentative conclusions may be drawn. If we contrast the behaviour of the PC's during their long tenure in power at Queen's Park with the behaviour of a hypothetical ideological party committed to an institutional model of social policy, the relationships between this party — let us call it the "social welfare party" — and the OAMR or other interest groups in the social welfare field would probably have been different. We might have expected social welfare interest groups to have established a formal working relationship with the government, and particularly with COMSOC. Such a relationship would have fallen into the corporate rather than into the co-optative or differentiated model. We might even have seen the establishment of a Board of Control or some kind of semi-independent body which would supervise and regulate the conduct of mental retardation policy. Although there might well have been friction between the social welfare party and social welfare interest groups, it is unlikely the social welfare party would have tried, or would have been able to ride roughshod over these interest groups. Moreover, the social welfare party would probably have devoted a lot of time, energy and funds to improving social welfare services.

By contrast, the PC's have behaved quite differently while in office. Although it is true that public expenditure on mental retardation policy has increased year by year, the percentage spent on mental retardation policy relative to total public expenditure during the decade from 1970 to 1980, is less than that percentage from 1880 to 1900. And when one

subtracts federal CAP funds from the total, the amount declines considerably. Yet the PC's did spend large sums of money on mental retardation policy and they did make some major changes in policy. But they have never taken the initiative in reforming policy, and have made changes only after immense pressure has been applied from the outside, mainly from the OAMR and from its predecessor OARC. The PC's have always been extremely cautious about establishing any kind of corporate or semi-corporate relationship with the OAMR. In keeping with the century-long tradition of bureaucratic centralization, the ultimate responsibility for mental retardation policy has rested exclusively in the hands of the bureaucracy. All suggestions for real decentralization of decision-making power have been rejected, beginning with Hodgins' ideas on a Board of Control in 1919, through C.A. Roberts' suggestions in 1963 that provincial hospitals be governed by autonomous boards as with the active treatment hospitals, to the OAMR's desire to establish semi-independent councils to supervise mental retardation policy in the various provincial districts. Everything points to the PC's desire to keep the bureaucracy in control of all aspects of mental retardation policy, from policy analysis through policy formulation, implementation and supervision.

But how does one characterize this kind of ideology? The answer is that it is extremely difficult to do so. Many people argue that the PC's have no ideology, that the very lack of a political doctrine accounts for their continued and astonishing success. It is of course true that the continued tenure in office of the PC's annoys and often enrages political opponents, while it always puzzles and sometimes dazzles the outside observer. During interviews, many respondents who belonged to the civil service, or had long acquaintance with the government claimed that the secret of the party's success lay in its opportunism, or as many of them liked to say its "sheer" opportunism. One civil servant commented: "The PC's wait until an issue or policy has become popular, it doesn't matter that the Liberals or the NDP may have raised it, if the PC's think they can win votes by taking it over, they will."[62] Certainly the term "opportunism" seems an apt description of the PC's behaviour in the area of mental retardation policy. The PC's had to be pushed quite hard to do something for mentally retarded people during the 1960's and 1970's. It is true that the OAMR was finally successful in 1969 in getting the Department of Education to take over their schools, but this was only after a long struggle. And while the government accepted the implications of the re-organization of mental retardation policy toward community integration after 1974, it completely ignored the thousands of mentally retarded people in Homes for Special Care.

According to the conventional wisdom the "Red Tory" strain in the Progressive Conservative party makes it particularly responsive to demands for social change. However, until one has detailed comparative histories of mental retardation policy in other jurisdictions there is no way

to assess the truth of this notion. The best one can say is that the Red Tory strain in Progressive Conservatism is manifested not so much in a preference or an inclination for social reform, but rather in the party's willingness to engage in social reform when pushed to do so. In contrast to American political parties, the Progressive Conservatives are not weighed down by an ideological baggage filled with weighty phrases such as "individualism," "rights of private property," "pluralism," "the evils of government," etc. One may occasionally hear Progressive Conservatives mouth such phrases, but they have never constituted an obstacle to, for example, collectivizing hydro-electric power or supporting a government funded hospital and medical insurance plan.

By not attaching itself too firmly to any particular social welfare doctrine, or to any set of social welfare interests, therefore, the PC's can remain flexible. Because the party is generally uncommitted it can respond flexibly to changes in public opinion, appearing now reformist, even socialist, at other times conservative or even reactionary. Thus, the opportunism of the PC's in this area is a style, an approach to politics rather than a particular set of policies. And whether or not one wants to generalize from the party's behaviour in the narrow field of mental retardation policy to its political behaviour in general, it is interesting that to the public the PC's consistently appear inoffensive and colourless. As William G. Davis, Premier of Ontario and one of the great practitioners of the style put it when an opposition member accused him of being bland: "But bland works."

This does not mean the PC's are completely without a guiding set of principles. Obviously this is not true, for as we have seen, the party tends to follow a residualist safety net approach in the area of social policy, and to maintain a co-optative relationship with the OAMR, as opposed to a corporate relationship with certain medical interest groups. Traditionally, the PC's have not given a high priority to social welfare policy, or to policies involving mentally ill, retarded, senile old or physically handicapped people. A recent study by the Ontario Welfare Council shows that spending on income maintenance programs in Ontario from 1971 to 1981 grew at a rate less than that of total provincial expenditures and far less than the increase in expenditures on social development policy or on COMSOC itself. During the years from 1975 to 1980, expenditure on income maintenance lagged even farther behind total provincial budgetary expenditures (7.7 percent for income maintenance as opposed to 10.1 percent for the budget). According to the report: "A comparison between spending trends in the first and the latter half of the seventies reinforced the conclusion that welfare recipients have been forced to carry a disproportionate share of the costs of restraint." And, the report says: "In Ontario, the poor have become poorer because it was government policy, not because the province could not afford more generous social assistance programs."[63]

Thus, the PC's are quite generous in funding social policies when the

provincial economy is prosperous and when there are federal cost-sharing funds available, but during periods of economic downswing, the government tries to save money at the expense of these same policies.[64]

Moreover, one should not expect the PC's to forge ahead in finding new directions for mental retardation policy. They are unlikely to launch crusades or radical new initiatives. But they will respond to pressure from the public, the press, interest groups, opposition parties and the federal government. In doing so, however, they will try to retain control over the direction of policy and to reject any suggestions of decentralizing decision-making power. They will also try to maintain a co-optative relationship with the OAMR or with any other emergent pressure group in the social policy field. Since the PC's have not given any ideological preference to mental retardation policy in the past, one should not expect them to do so in the future. And as COMSOC continues to grow in size and to develop its research and policy analysis capabilities, the bureaucracy will become increasingly the major locus of policy formulation. Thus, even the local associations of the OAMR will be further restricted to fulfilling a service function, and the OAMR may be relegated to performing a secondary role as a sidelines critic or advocate.

12

The Welfare State and the Social Service State

In one way or another the government of Ontario has been dealing with mentally ill and mentally retarded people for more than 140 years. Long before anyone had thought of the term welfare state, the government fed, clothed and housed mentally ill and mentally retarded people. The government assumed these responsibilities because of the influence of humanitarianism and because medical science in the 1840's and 1850's believed that with proper treatment mentally ill people might be cured and mentally retarded people educated. These early hopes were quickly dashed, but once the government had embarked upon a course of providing care for these groups, an overwhelming public response made it impossible to turn back. By the end of the nineteenth century the government was under immense pressure to build additional institutions. Part of the reason was that families and communities now had some alternative to placing mentally ill and mentally retarded people in local jails, but part of the reason as well was that while the government intended the large institutions specifically for "lunatics" and "idiots," the community saw in them a convenient means for disposing of unwanted elderly, senile, delinquent, immoral or other deviant people. This looks like a clear-cut case of the unintended consequences of policy making themselves felt. But one must be careful to distinguish between those whose objectives were being thwarted by the direction policy was taking, and those whose objectives were being met. One the one hand, it is quite true that the social reformers, government bureaucrats and medical superintendents who supported or manned the various lunatic and idiot asylums in the middle of the nineteenth century were frustrated and disappointed at the inundation of their institutions by people who were not the intended targets of policy. On the other hand, families, local communities and local institutions which could not or would not deal with these people

were quite willing to use existing policy for their own purposes. Whereas the first group wanted to use the institutions for curing the insane or educating mentally retarded people, the second group wanted to use the institutions as asylums or for social welfare purposes.

During this period mental retardation policy was the responsibility of an extremely small circle of civil servants mainly working in the inspectorate and in the office of the Provincial Secretary. Politicians, voluntary organizations and the press were either ignorant of, or generally indifferent to government policy. It was not until the rise of the myth of the menace of the feeble-minded at the end of the nineteenth century that voluntary organizations became interested in the question.

Because of the activities of these groups, and because they linked the problem of feeble-mindedness to some of the most pressing social problems of the day, mental retardation policy became one of the major issues on the political agenda. The press, politicians and pressure groups were caught up in the campaign to "do something" about the feeble-minded. As a result, many mentally retarded people partially benefited and partially suffered from the sudden interest in their presence. On the one hand, they benefited from the fact that public education and public health were considered appropriate responses to the problems of poverty, crime, delinquency and immorality. Since mentally retarded people were linked to these problems, providing special classes for slow learners, and educating mothers about proper nutrition and child care were positive steps in the care of mentally retarded people. On the other hand, and for exactly the same reasons, that is, the assumed relationship between major social problems and mental retardation, and because of mistaken beliefs about the promiscuity of mentally retarded women and the mechanisms of heredity, mentally retarded people, particularly single mothers, were liable to life-long incarceration in large custodial institutions if they were unfortunate enough to break the law or were committed by parents, relatives or public authorities.

Whether mental retardation policy was intended to provide asylum, education, or to function as a mechanism of social control or social welfare, the general condition of mentally retarded people in large custodial institutions during the nineteenth and early part of the twentieth centuries was no better than that of the poor, the elderly or any other severely deprived or handicapped group. Only prisoners in local jails or federal prisons lived in worse conditions.

With the disappearance of the myth of the menace of the feeble-minded in the late 1920's mental retardation once more disappeared from public view, again becoming the concern of a small circle of civil servants in the office of the Provincial Secretary (and later in the Department of Health), and of the various superintendents and physicians in the provincial mental retardation facilities. Although research had already demonstrated that a majority of mentally retarded people could lead normal lives in the community with a minimum of help, the social service infra-

structure and the political will to re-orient policy toward community care were lacking. Reformers such as Dr. B.T. McGhie were helpless in the face of this situation. And while new ideas about the nature and social implications of mental retardation continued to appear during the 1920's and 1930's policy hardly changed. Only with the entry into the political arena of parents' groups in the 1950's in Ontario did the slow process of change begin. Thanks to the unremitting efforts of parents and volunteers, mental retardation policy gradually moved out of the narrow circle of government bureaucrats and became a truly public issue. Now the press, politicians from all parties, voluntary organizations, academics, intellectuals and even the public began to play a role in the policy process. Despite the fact that government was no longer completely indifferent to the plight of mentally retarded persons, it still took an immense amount of pressure before policy changes were made. Even then progress was uneven. While the schools run by local associations were fully integrated into the public school system in 1969, by 1980 more than two thousand elderly or severely handicapped people continued to languish in private nursing or residential homes, always ignored, sometimes badly treated. And despite the appparent commitment to deinstitutionalization, the large mental retardation facilities continue to operate although on a reduced scale.

Thus, for more than a century and a half, depending on the particular historical conjuncture, mental retardation policy oscillated among four principal objectives: to provide asylum, to fulfill social control functions, to educate mentally retarded people, or to serve social welfare functions. Sometimes one or another of these goals has been dominant, sometimes some or all of them have been served simultaneously.

Mental retardation policy has been composed of a number of strands because mentally retarded people may also be criminals, multiply handicapped, poor, unemployed, delinquent, single mothers, schoolchildren, etc. Frequently it is a matter of sheer accident as to whether they fall within the scope of programs aimed specifically at mentally retarded people or wind up in programs aimed at other kinds of problems. Moreover, someone may be the target of a program aimed at the poor, the delinquent or the unemployed, but then be re-labelled as mentally retarded and shifted to a different program.

During the nineteenth century it was Orillia and Orillia alone that was intended to serve the goals of mental retardation policy. But as the scope of government social policy expanded during the period after Confederation, inevitably, mentally retarded people were found in the educational, health, social welfare and penal systems. Thus, the multiple goals of mental retardation policy were served by a bewildering variety of government policies and programs, many of them not specifically designed for or aimed at mentally retarded people. Moreover, the quality of these programs varied widely, depending upon program objectives, the professionals who manned them, and the clientele they served. Generally,

though, those programs aimed at the handicapped, deprived, or dependent classes were of the lowest possible quality.

Within the health system, for example, there have always been quite distinct levels of care provided for different categories. Chronically ill, mentally ill, and mentally retarded people have always received a much lower level of care than that provided to those in active treatment hospitals. Part of the reason is that those who could afford to, resorted to private institutions, thus leaving public institutions to the poor. In the case of mentally retarded persons, for example, it appears that until very recently, wealthy parents sent their retarded dependents to private institutions in the United States. Moreover, with the rise of the myth of the menace of the feeble-minded from 1900 to 1930, the stigma of being mentally retarded was attached to the institutions themselves, and this gave government an excuse for not providing more than minimal funding for mental retardation programs. And part of the reason for the poor quality of care traditionally given to mentally retarded people has to do with the sociology of medicine.

During the nineteenth century, the authority and prestige of the medical profession depended to a great extent on the assumed moral character and personality of the doctor. The major advances in health during this period were due more to changes in public health rather than to the skills or techniques of the medical profession. By the beginning of the twentieth century, however, medicine was increasingly linked to science, and with the rise of drugs and high-technology medicine, its prestige derived from its ability to alleviate or cure illness. There was now little point to working with groups not amenable to the new scientific techniques of modern medicine. This meant that doctors were even less attracted than before to dealing with chronically ill, senile old, mentally ill and mentally retarded people. Thus, when they became ill and fell within the active treatment system, mentally retarded people were as likely as anyone else to get as high a level of care. But this was not true of the level of care provided within mental retardation programs.

In order to better distinguish between those programs which do provide a high level of care to mentally retarded people and those which do not, we might take as a rough criterion the following statement from the Declaration on the Rights of Mentally Retarded Persons adopted by the General Assembly of the United Nations on December 20, 1971.

> The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

In Ontario today, it appears that the health care system does provide "proper medical care and physical therapy" for mentally retarded persons, and that the educational system does try to help "him to develop

his ability and maximum potential."

But these are about the only programs which achieve these objectives. Most of the other programs within which mentally retarded people fall are of very poor quality. For example, since 1964 the Homes for Special Care program has borne an uncanny resemblance to the asylum policy of the late nineteenth century. Then, as now, the main goal was to provide asylum for people who could not physically survive in the community. But nothing more than the minimal necessities of food, clothing and shelter were provided. And whereas in 1980 there was evidence that the government intended to provide additional help for mentally retarded people in this program, a series of articles in the Toronto *Globe and Mail* in March 1981, called attention to the scandalously poor conditions in which elderly people were kept in nursing homes licensed by the province.[1] Of course, the administration and funding of the Homes for Special Care differs markedly from the administration and funding of asylums and houses of refuge in the early part of this century. Whereas now the program is administered largely by untrained private operators who run the homes for profit and derive their income from government subsidies, in the nineteenth century, asylums and houses of refuge were fully funded by either the provincial or municipal governments. And whereas in the nineteenth century the inspectorate seems to have taken its job quite seriously, accumulating comparative data, suggesting changes and improvements and writing detailed reports on all aspects of policy, by the middle of the twentieth century inspections had become perfunctory, sporadic, secret, and ignored by government.

Amid the often bewildering variety of new programs dealing with the needs of mentally retarded people, and against all expectation, the large institutions continue to play a central role. Over the years their role has evolved, and they have responded creatively (and in the interests of self-preservation) to each new change in the objectives of mental retardation policy. They still continue to provide asylum for mentally retarded people who cannot survive in the community. They educate people in institution schools; they fulfill a social welfare function for those mentally retarded people who might function in the community but may suffer from emotional or social problems which make integration difficult, and they have expanded the range of social welfare functions they provide to the community.

But it is the social welfare function of mental retardation policy that has emerged as the most important aspect of policy. Through cash transfers in the form of Family Benefits payments, the subsidization of group homes, social workers, residences, apartments, sheltered workshops, etc., government is now committed to integrating and maintaining large numbers of mentally retarded people in the community.

Has this shift in policy meant an improvement in the situation of mentally retarded people? Certainly when compared with conditions 50 or 100 years ago mentally retarded people are better off now than before.

But when one asks whether the relative position of mentally retarded people has improved vis-à-vis other dependent groups then the question becomes more difficult to answer. The reason is that one must judge mental retardation policy against the available alternatives, not against an ideal standard.

For many years the alternatives were indeed grim — local jails, houses of refuge or possibly abandonment in the community. At times, the relative position of mentally retarded people has been slightly better, at times worse than that of other groups. But at no time has there been a permanent qualitative change in their relative position. For more than a century, from the 1840's to the 1960's mentally retarded people in Ontario were ignored, institutionalized or stigmatized. By the late 1970's many of them were being gradually integrated into the general social welfare population, but they were still at the bottom of the social and economic ladder, submerged in the large underclass that seems to be a permanent feature of advanced industrial societies.

Thus the government has not solved the "problem" of mental retardation by transferring mentally retarded people from the large institutions to the community. Basically all that has happened over the past decade is that mental retardation policy finally caught up with the general shape and level of the other provincial social policies. Whereas mental retardation policy in the 1950's and 1960's (with the honourable exception of the schools) was a monument to a policy centred on large institutions and derived from a social structure and a conception of social policy that had disappeared decades before in other areas, by 1974 mental retardation policy was being increasingly aligned with contemporary thinking about community care, and family support for dependent groups. At the same time, mentally retarded people were falling within the scope of a number of different programs not directly aimed at mentally retarded people, the most important of which was the provincial social welfare program.

Clearly, then, the future treatment of mentally retarded people is inextricably linked with the future of a variety of social policies, some of which are specifically intended to help mentally retarded people, but some of which are aimed at a wide variety of deprived, handicapped or dependent groups. Generally these policies are thought of as comprising part of the welfare state. But it is important to distinguish between the welfare state and the social service state, and between the policies characteristic of each. The British historian Asa Briggs has defined them as follows:

> A "welfare state" is a state in which organized power is deliberately used (through politics and administration) in an effort to modify the play of market forces in at least three directions first, by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second, by narrowing the extent of insecurity by enabling individuals and families to meet

> certain "social contingencies"(for example, sickness, old age and unemployment) which lead otherwise to individual and family crises; and third, by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services.
>
> The first and second of these objects may be accomplished, in part at least, by what used to be called a "social service state" a state in which communal resources are employed to abate poverty and to assist those in distress. The third objective, however, goes beyond the aims of the "social service state." It brings in the idea of the "optimum" rather than the older idea of the "minimum." It is concerned not merely with abatement of class differences or the needs of scheduled groups, but with equality of treatment and the aspirations of citizens as voters with equal shares of electoral power.[2]

The important point that Briggs makes here is that social policies often associated with the welfare state have a history which in some cases (the Elizabethan Poor Law is one example) extends as far back as the sixteenth century. By 1797, the idea of the social service state had been clearly formulated by Sir Frederic Morton Eden:

> The necessity of a permanent establishment for supporting the poor is, I conceive, admitted to a certain degree, in every country, in which there are public schools for the education of their children, dispensatories from which medicines are gratuitously supplied; hospitals for the reception and cure of the sick; or almshouses for lodging and maintaining the aged and necessitous.[3]

Thus it is not just "the expansion of government activities" as one Canadian scholar has put it, that defines the welfare state, for in this case one can lump together anything and everything the state has ever done, from legislation in the areas of public health, factories, and education, to public libraries, child welfare, etc., under this rubric.[4] Rather, the term welfare state has been used in an often confusing variety of ways. Sometimes it refers to actual states or countries as in the "Swedish Welfare State," while at other times it refers to a single social policy or to a congeries of social policies as "welfare state policies," while at still other times it refers to a way of thinking, an attitude or an ideology as in a "welfare state ideology."

However, if we put aside the references to entire social systems or to welfare state mentalities, it is possible to stipulate the attributes of welfare state policies by drawing on the writings of historians and theorists of the welfare state such as Asa Briggs, T.H. Marshall, Richard Titmuss and others. Briefly, welfare state policies should have the following attributes. They should be institutional, that is, integrated into the social sys-

tem, not as "regrettable necessities to be retained only until the capitalist system has been reformed or socialised, they are a permanent and even a glorious part of the social system itself. They are something to be proud of, not to apologize for."[5] They should also be open to people on the basis of need, that is, they should not be means tested. They should provide service at a level equal to or perhaps higher than that available in the private sector. They are expected as well to bring about a redistribution of income or of life chances in the direction of greater equality, or, as Asa Briggs puts it, to help "abate class differences." And finally, they should not stigmatize either their clients or those who work to implement them.

It is possible to quarrel with any one or all of these criteria, but it is undeniable that stated in this way welfare state policies contrast sharply with the policies of what used to be called the social service state. One has merely to reverse the criteria for welfare state policies to arrive at a definition of policies that fall under the rubric of the social service state. These policies are only weakly defended by governments and are always under enormous political pressure for retrenchment; they are usually means tested; the quality of service provided is usually lower than that available to those who can afford access to the private sector; they have little or no redistributive effect, and they are often stigmatizing. Given these definitions it appears that there are few social policies which conform to Briggs' ideal of the welfare state "optimum" and very many policies which conform to the social service state notion of a "minimum."

For example, mental retardation always has and still falls within the social policies of the social service state. During the nineteenth and twentieth centuries government assumed financial and administrative control over mental retardation policy, but its objective was never to provide an optimum level of care, but rather the barest possible minimum. Public institutions and services for mentally retarded people grew up because nineteenth- and twentieth-century societies have been at least humanitarian, and its citizens have not countenanced letting those who cannot help themselves starve in the streets. But beyond providing mere subsistence care, the state has felt little responsibility for the plight of mentally retarded people. And such changes as did occur were inspired by factors exogenous to the state, mainly because of the activities of pressure groups, moral entrepreneurs such as Helen MacMurchy or, after 1945, because of criticism from opposition political parties.

By contrast, there are two social policies which are exemplars of the welfare state: education and health care (Canadian and English style). Both systems are open to all citizens on the basis of need rather than ability to pay. Both conform to Brigg's idea of providing optimum levels of treatment and both are, in T.H. Marshall's terms, vaunted aspects of the system.

But why should this be so? Why the contrast between social service policies and welfare state policies?

Perhaps the answer can be found by looking at an argument common

to both the supporters and opponents of the welfare state. According to proponents such as Karl Polanyi, E.H. Carr and H.L. Beales, the rise of the modern welfare state was a necessary reaction by government to the depredations of capitalism.[6] In their view, if measures to mitigate the worst effects of capitalism had not been taken, the lower classes would eventually have either fallen into anarchy or resorted to violence. Opponents of the welfare state, such as Frederich A. Hayek and Ludwig von Mises argue that the laissez-faire liberal state of the nineteenth century was well on the way to solving the major social problems of the time, but that it was deflected from its purpose by a collaborative effort between the organized working class and certain large businesses fearful of the economic consequences of free competition.[7] Both agreed to the establishment of social policies: the trade unions because of the membership's desire for some protection from economic insecurity, and big business because social policies undercut the possibility of violent revolution. In this same vein, John Saville, the English historian, argues that social policies were concessions wrung from the ruling classes by the working class and that "in the last resort" the establishment of all social policies can be explained this way.[8] And often quoted in support of the view that social policies are an instrument for preventing revolt is the famous remark of Joseph Chamberlain, the Radical Mayor of Birmingham, England, who asked in a speech on social policy: "I ask what ransom will property pay for the security which it enjoys?"[9]

As proof of the contention that social policies are a sophisticated form of bribery, some left-wing critics have tried to demonstrate that the middle and upper classes benefit more from the health care and education policies of the welfare state than do the lower classes. But whatever else may divide the supporters and critics of the welfare state, they are agreed on one point — the welfare state came about because of the political pressure exerted by powerful forces in society.

If we accept these arguments about the origin and function of the welfare state as generally true, then where do mentally retarded people stand? Although scholars usually think of society as divided into a working, middle and upper class, nevertheless, from Marx on down to contemporary sociologists, reference has often been made to a class or stratum which ranks below the working class. It is variously referred to as the "lumpen-proletariat," "demoralized residuum," the "wholly degenerate," "the dangerous class," the "residuum," or as the "lower one-tenth" or "one-fifth."[10] For Marx this group consisted of people who lacked any sense of class consciousness, and who were so demoralized that they were more likely to side with the bourgeoisie during periods of class conflict than with their natural allies in the working class. Most commonly this stratum has been thought of as politically powerless on its own, but potentially dangerous when allied to other restive or radical groups. Sometimes mentally ill and mentally retarded people have been counted in their number, and when this has occurred, as during the period

of the myth of the menace of the feeble-minded, they have been the object of social policies partly motivated by a desire for social control. However, even during these periods, those mentally retarded people who were thought to be trainable or educable escaped the worst aspects of punitive social policies.

But the point is that mentally retarded people, like the "residuum," have been the objects of social policy, never the subjects. Unlike the organized working class, they have never made their own history, and it is only because they have been represented by interest groups since 1945, that their presence has been felt on the political scene. Historically, mentally retarded people and other similar dependent groups have constituted a litmus test for the social theories and ideologies of an age, for they have usually reflected in an almost completely objective way whatever those theories have been. During the nineteenth century when religion was gradually being replaced by humanitarianism as the basis for social policy, government policy toward mentally retarded people changed accordingly. And as humanitarianism began to reflect industrialist capitalist ideas about the nature of the lower orders, and about the relation between government expenditure and social policy, so, too, did mental retardation policy mirror these changes.

Thus social policies aimed at mentally retarded, mentally ill and other people have been inspired more by what society thought of them, rather than by what they demanded or wrested from society. It is true that after 1945, pressure from parents' organizations such as the OAMR forced government concessions, but it is arguable that the OAMR never really obtained a foothold in the bureaucracy, and that government is increasingly able to override its opposition when it wishes to do so.

The differences between social policies based on a social service mentality, and social policies wrung from government by political pressure and part of the welfare state mentality is summed up in Briggs' distinction between the minimum and the optimum. The social service state typically consists of programs for mentally ill, mentally retarded, chronically sick, senile old and physically handicapped people. These programs are usually needs or income tested, the quality of service provided is often low, the clients stigmatized, funding is niggardly and the administration is often repressive. These policies are established only grudgingly. The politicians and bureaucrats responsible for them usually take the role of watchdog or critic. By contrast, the welfare state consists of social policies, mainly those associated with education and health care, which are open to all, where the quality of service is high, clients are not stigmatized and funding is generous. The politicians and civil servants see themselves as defenders of these programs, and take the side of their clients as against outside critics.[11]

The difference between the social service state and the welfare state may also be characterized in terms of the differential levels of power and

prestige of those who man the social programs in the two systems. The teachers, administrators and professors in the educational system, and the doctors, specialists and health administrators who staff the health care system are largely recruited from the middle and upper classes. They have powerful organized pressure groups to protect their interests. They are often well entrenched within government, sharing decision-making or consultative powers with the bureaucracy. Since much of the cost of the welfare state goes into the salaries of these highly paid, prestigious and powerful professionals, they have an immense stake in defending the system against attack.

By contrast, the social workers, volunteer workers, government bureaucrats, and clientele of the social service state have much less power and prestige. Except for the OAMR, pressure groups in the social service state in Ontario are weak and incoherent, while those who man the system belong to civil service unions, or public service employee unions which are weak and often ineffective.

It is ironic, therefore, that the current attack on the "welfare state" is really directed at those groups which benefit the least from the social policies associated with the welfare state, and depend most on the social policies attached to the social service state. For mentally retarded adults, mentally ill, senile old or chronically ill people, the excellent public education system in Ontario has little relevance. Nor does the medical and hospital insurance plan. For their day-to-day existence, these groups must depend on the social assistance and social service programs of the social service state. These have traditionally fallen far short of the ideal of the optimum.

Thus, what we have now and have had for some time are really two systems: a welfare state system which grew out of, but is a vast improvement over an older social service system, and a social service system which continues to serve the needs, at a minimal level, of the unemployed, the poor, old, mentally ill, mentally retarded, handicapped, indeed all the oppressed or deprived minorities which have been a permanent feature of western society for centuries.

The history of mental retardation policy in Ontario, therefore, is not one of unremitting progress, of a society which has become increasingly aware of, and willing to devote a larger proportion of its resources to the needs of mentally retarded people. Rather, mental retardation policy is part and parcel of the history of the social service state. Certainly mentally retarded people are no longer incarcerated for life in enormous custodial institutions where they are, at best, ignored or, at worst, maltreated. But for that matter, neither are the poor put into houses of refuge or allowed to wander abroad without any help. Thus, it is not the absolute position of the dependent classes that has remained unchanged, but rather their position relative to the rest of society. Whereas some groups have benefited from welfare state policies, other groups still form the clientele of policies which have survived from, indeed which constitute the living

structure of a social service state and a social service mentality. This is both the fate and the challenge of mentally retarded people.

Notes

Chapter 1

1 Upper Canada, *Journal of the House of Assembly,* January, 20, 1831. Jarvis presented a bill to establish an asylum for the insane and destitute in connection with the York hospital. On February 4, 1833 the Committee of Supply reported a bill for procuring plans and estimates for an asylum for insane persons. On the early history of institutional care for the insane, see Alfred E. Lavell, "The Beginning of Ontario's Mental Hospitals," *Queen's Quarterly,* Volume 49 (Spring, 1942), pp. 59-67, and T.J.W. Burgess, "Canadian Institutions for the Insane,"*Royal Society of Canada: Proceedings and Transactions,* Volume 4, Second Series, Section 4 (1898), pp. 3-122. Burgess notes that "between 1830 and 1839 numerous attempts were made in the legislature toward the institution of an asylum, all of which, however, proved abortive (p. 14)." See also Henry M. Hurd, editor, *The Institutional Care of the Insane in the United States and Canada,* 4 volumes (New York, 1973 reprint of 1916-17 editions). Volumes I and IV contain material on Canada.

2 *Journal of the House of Assembly,* 1836, Volume I, Appendix no. 20, p. 3.

3 *Ibid.*, p. 5.

4 *Ibid.*, p.7.

5 Upper Canada, *Statutes,* 1839, c. 11.

6 Quoted in W. Canniff, M.D. *The Medical Profession in Upper Canada* (Toronto, 1894), p. 148.

7 The Toronto *Globe* quoted by J.M.S. Careless, in "A History of the Provincial Lunatic Asylum," *City Magazine,* Volume 2, (Summer, 1976), p. 42. Although Howard's design won general approval, the actual construction of the asylum seems to have been faulty. When Dr. Joseph Workman was given temporary charge on January 1, 1853, the foul odours he encountered led him to investigate the building:

The general health of the establishment was unsatisfactory and the appearance of the patients too clearly indicated that serious defects in the sanitary provisions of the house existed.... Every apartment abounded with foul air and it was found that beneath the basement floors, covering a space of six hundred feet in length by thirty to one hundred feet in breadth, there had from some undiscovered cause accumulated a mass of filth and impure fluids the stench from which when first exposed was so insufferable and overpowering as instantly to sicken several of those who, including the Visiting Commissioners, chanced to inhale it.... In the eastern division of the house beneath the kitchen and adjoining parts, the filth was found to measure from three to five feet in depth and was of varying consistency, from that of dense mud to thin molasses. The superjacent floors and joists were so rotten as to yield under every passing foot, and in several places had given way, leaving openings from which issued the most offensive effluvia. A rank fungous vegetation hung from under the surface of the decayed timbers.... The cause of the bad state of the foundation was discovered to have been a defect in the deep drainage of a most unaccountable character. The interior drains from the kitchens, laundries and other parts being followed from their sources to the points of emergence from the buildings were found to be further impenetrable having never been carried out to the main sewer which was at the short distance of 22 feet.

This state of things had gone on for five years before Workman's discovery. See Province of Canada, *Journals*, 1854/55, Volume 13, Appendix 7 (H).

8 Province of Canada, *Journals*, 1841, Volume 1, Appendix (LL).

9 Quoted in Daniel Hack Tuke, *The Insane in the United States and Canada* (London, 1885), p. 214. Tuke refers to Workman as a "Nestor" on page 216.

10 *Ibid.*, p. 214.

11 Province of Canada, *Journals*, 1851, Volume 10, Appendix 1 (C) p. 1.

12 Dr. David Boyle, "Notes on the Life of Dr. Joseph Workman," read before the Canadian Institute April 21, 1894. Located in the Library of the Academy of Medicine, Toronto.

13 Province of Canada, *Journals*, 1854/55, Volume 13, Appendix 7 (H), p.6.

14 *Ibid.*, Statutes, 1851, p. 83.

15 *Ibid.*, *Journals*, 1854/55, Volume 13, Appendix 7 (H), p. 6.

16 *Ibid.*, p. 3.

17 *Ibid.*, 1858, Volume 16, Appendix 4 (9), p. 6.

18 *Ibid.*, *Sessional Papers*, 1861, Volume 19, no. 24. This practice continued throughout the latter part of the nineteenth century. For the fobbing-off process at work in the jails, see Donald G. Wetherell, "To Discipline and Train: Adult Rehabilitation Programmes in Ontario Prisons, 1874–1900," *Social History* Volume 12, (May 1979) pp. 151-152.

19 On the history of poor relief during this period, see Richard B. Splane, *Social Welfare in Ontario: 1791–1893* (Toronto, 1965), pp. 65-79. For an ex-

planation of the resistance to organizing a system of poor relief in Toronto, see Joey Noble, " 'Class-ifying' the Poor: Toronto Charities, 1850–1880," *Studies in Political Economy,* Volume 1 (Autumn 1979), pp. 109-128. Also see Stephen Speisman, "Munificent Parsons and Municipal Parsimony," *Ontario History,* Volume 65 (March 1973), pp. 34 ff.

20 Upper Canada, *Statutes,* 1839, c. 11 and 1853, c. 188.

21 Albert Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times* (Garden City, New York, 1937), p. 236.

22 Province of Canada, *Journals,* 1856, Volume 14, Appendix 1.

23 Province of Canada, *Sessional Papers,* 1863, Volume 21, no. 66, p. 6.

24 Province of Canada, *Sessional Papers,* 1861, Volume 19, No. 24, p. 4.

25 See, for example, the various articles in the *Journal of Insanity* by J. Mundy, "On the Various Modes of Public Provision for the Insane," *Journal of Insanity,* Volume 21 (1864–1865), pp. 533-555; Anonymous, "The Willard Asylum and Provisions for the Insane," Volume 22 (1865–1866), pp. 192-212; Anonymous, "Summary: On Separate Asylums for Curables and Incurables," Volume 22, (1865–1866), pp. 246-252 and "Proceedings of the Association," Volume 23 (1866–1867), pp. 150 *et passim.*

26 Province of Canada, *Journals,* 1857, Volume 15, Appendix 4 (12), p. 2

27 *Ibid.,* p. 4.

28 Province of Canada, *Sessional Papers,* 1863, Volume 21, No. 66. p. 3.

29 Anon., "Summary," *Journal of Insanity,* Volume 23 (1866), p. 259.

30 Province of Canada, *Sessional Papers,* 1866, Volume 26, No. 6, pp. 30 ff.

31 George Cook, M.D., "Provision for the Insane Poor in the State of New York," *Journal of Insanity,* Volume 23 (1866), p. 46.

32 Benjamin Workman, M.D. "The Chronic Insane of Upper Canada," *Ibid.,* Volume 24 (1867), pp. 42-51.

33 Province of Canada, *Sessional Papers,* 1863, Volume 21, No. 66, p. 46.

34 *Ibid.,* p. 93.

35 *Ibid.,* pp.91-93.

36 *Ibid.,* 1866, Volume 26, No. 6, pp. 38-39.

37 Andrew T. Scull argues that medical doctors were no better qualified than anyone else to care for the insane, but that in order to assert their authority in the field they coined an abstract and esoteric vocabulary to impress and baffle laymen, and that they claimed that insanity resulted from somatic causes, mainly brain lesions, so as to link insanity with already accepted medical practices and theories. The difficulty was that medical and psychiatric theories were quite tenuous and so asylum superintendents were always fighting a defensive battle against outside critics. Scull goes on to argue that "the asylum doctor's inability to do anything for the overwhelming majority of their patients meant that interaction with inmates threatened daily discon-

firmation of their effectiveness. In this situation being asked to undertake impossibly heavy caseloads in a patently over-large institution provided the profession with convenient scapegoats on which to blame many of its troubles." Andrew T. Scull, "Mad-Doctors and Magistrates," in *European Journal of Sociology,* Volume 17 (1976), p. 297. In this context, Workman's honesty about the importance of his role is certainly surprising.

38 Province of Canada, *Sessional Papers,* 1865, Volume 25, No. 14, p. 8.

39 *Ibid.*, 1866, Volume 26, No. 6, p. 14.

40 *Ibid.*, p. 13.

41 See Leo Kanner, *History of the Care and Study of the Mentally Retarded* (Springfield, Illinois, 1967), p. 41.

42 *Ibid.*, pp. 41-42.

43 Quoted in Wolf Wolfensberger, *The Origin and Nature of Our Institutional Models* (Syracuse, New York, 1975), p. 25.

Chapter 2

1 Upper Canada, *Statutes,* 1839, c. 11, "An Act to authorize the erection of an asylum within this province for the reception of insane and lunatic persons."

2 *Ibid.*, 1853, c. 88.

3 Province of Canada, *Sessional Papers,* 1860, Volume 18, No. 32, p. 5.

4 *Ibid.*

5 *Ibid.*, p. 6.

6 *Ibid.*, 1862, Volume 20, No. 19, pp. 61-62.

7 *Ibid.*, 1863, Volume 21, No. 66, p. 12.

8 Dr. J.C. Taché, in *Ibid.*, p. 8.

9 *Ibid.*, 1864, Volume 23, No. 39, p. 8.

10 Ontario, *Statutes,* 1868, c. 21, "The Prison and Asylum Inspection Act."

11 Richard B. Splane argues that cost cutting motives inspired this change since the previous three full-time inspectors drew annual salaries of $2,000 plus travel expenses of $1,050, while the new Inspector's salary was $2,000 plus expenses. See Splane, pp. 45-46.

12 *Ontario Sessional Papers (hereafter referred to as* OSP*),* 1868/69, Volume 1, Part 1, No. 3, p. 3.

13 According to the existing statute, the immediate family, that is, the father, mother or guardian of a lunatic under the age of 21 were liable for maintenance expenses if they were "able to pay." Over the age of 21 the lunatic was assessed for maintenance costs on the basis of his real or personal property. See *Upper Canada, Statutes,* 1853, c. 188.

[14] OSP, 1869, Volume 2, No. 4, p. 25.

[15] OSP, 1875/1876, Volume 8, No. 4, p. 18. Much the same point was made 106 years later by a group of civil servants enquiring into residential care services in Ontario. Criticizing wide variations in the "life styles" within residential care institutions, they noted: "High cost styles of life in residential care, some of which can only be enjoyed by the wealthy in the community, appear to have little or no direct bearing on the service needs of the individual or the results of care. In the children's field particularly, it may be counter-productive to introduce them to a high style of life over a period of one or two years which will be radically reduced when they return to the community." Ministry of Community and Social Services, *Report of the Interministry Committee on Residential Services,* April 14, 1975, p. 5.

[16] Quoted in Charles E. Rosenberg, "And Heal the Sick: The Hospital and the Patient in 19th Century America," *Journal of Social History* Volume 10 (Summer, 1977), p. 438.

[17] For example, in 1873, Langmuir reported of London: "Owing to the bad plastering throughout the Asylum, over a sixth of the entire ceiling surface has fallen down. The wood-work and flooring are of the worst kind, both in respect to material and workmanship, and the painting generally throughout the asylum is very inferior. The windows are so badly fitted that not over half of them can be opened without sending for the carpenter." OSP, 1873, Volume 5, Pt. 1, No. 2, p. 23.

[18] *Ibid.*, p. 9.

[19] *Ibid.*, p. 14.

[20] *Ibid.*, 1869, Volume 2, No. 4, p. 63.

[21] *Ibid.*, p. 63.

[22] *Ibid.*, 1873, Volume 5, Pt. 1, No. 2, p. 14.

[23] *Ibid.*, 1871/72, Volume 4, No. 4, p. 103.

[24] *Ibid.*, 1873, Volume 5, Pt. 1, No. 2, p. 17.

[25] *Ibid.*, p. 162.

[26] *Ibid.*, p. 162.

[27] *Ibid.*, 1871/72, Volume 4, No. 4, p. 106.

[28] *Ibid.*, 1873, Volume 5, Pt. 1, No. 2, p. 160.

[29] *Ibid.*, 1874, Volume 6, Pt. 1, No. 2, p. 171.

[30] *Ibid.*, p. 3.

[31] *Ibid.*, 1873, Volume 5, Pt. 1, No. 2, p. 8.

[32] *Ibid.*, 1875/1876, Volume 8, No. 4, p. 2.

[33] *Ibid.*, 1877, Volume 9, Pt. 1, No. 2, p. 37.

[34] Quoted in Janet Shea, *History of the Ontario Hospital School (Orillia)* (unpublished MS), Library, Huronia Regional Centre, Orillia, Ontario, 1973.

[35] OSP, 1874 Volume 7, No. 2, p. 2.

[36] *Ibid.*, 1877, Volume 9, Pt. 1, No. 2, p. 38.

[37] *Ibid.*, 1878, Volume 10, Pt. 2, No. 4, p. 35.

[38] *Ibid.*, 1880, Volume 12, Pt. 2, No. 8, p. 10.

[39] *Ibid.*, 1881, Volume 13, Pt. 2, No. 8, p. 368.

[40] *Ibid.*, 1882/83, Volume 15, Pt. 4, No. 8, p. 3.

[41] *Ibid.*, p. 4.

[42] *Ibid.*, p. 4.

[43] *Ibid.*, 1885, Volume 17, Pt. 4, p. 49.

[44] *Ibid.*, 1884, Volume 16, Pt. 3, No. 47, p. 15.

[45] Dr. W.T. O'Reilly to Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons, *Proceedings*, (1885), Session 10, p. 350.

[46] OSP, 1896, Volume 28, Pt. 3, p. 213.

[47] *Ibid.*, 1897, Volume 29, Pt. 4, p. 255.

[48] *Ibid.*, 1893, Volume 25, Pt. 3, No. 8, p. 142.

[49] Ontario, *Financial Statement of the Honorable A.M. Ross*, February 21, 1884,

[50] OSP, 1879, Volume 11, Pt. 3, p. 25.

[51] *Ibid.*, 1882/83, Volume 15, Pt. 4, p. 13.

[52] *Ibid.*, 1895, Volume 27, Pt. 2, p. xiv.

[53] *Ibid.*, 1884, Volume 16, Pt. 3, No. 47, p. 12.

[54] *Ibid.*, 1903, Volume 35, Pt. 8, No. 8, p. 106.

[55] *Ibid.*, 1895, Volume 27, Pt. 2, pp. 18-19.

[56] *Ibid.*, 1884, Volume 16, Pt. 3, No. 47, p. 18.

[57] *Ibid.*, 1885, Volume 17, Pt. 4, p. 58 and n.

[58] *Ibid.*, 1887, Volume 19, Pt. 1, p. 91.

[59] *Ibid.*, 1890, Volume 22, Pt. 3, No. 10, p. 101.

[60] *Ibid.*, 1889, Volume 21, Pt. 6, No. 61, pp. 2-33.

[61] *Ibid.*, p. 17.

[62] Province of Canada *Statutes* 1853, c. 188.

[63] OSP, 1869, Volume 2, No. 4, p. 27.

[64] *Ibid.*, 1870/71, Volume 3, No. 6, p. 44.

[65] *Ibid.*, 1882, Volume 14, Pt. 4, No. 8, p. 22.

66 *Ibid.*, 1875/1876, Volume 8, No. 4, p. 224.

67 *Ibid.*, 1880, Volume 12, Pt. 2, No. 8, p. 389.

68 *Ibid.*, 1884, Volume 16, Pt. 3, No. 47, pp. 18-19.

69 *Ibid.*, 1889, Volume 21, Pt. 1, No. 1, pp. 44-51.

70 On the Patrons of Industry see S.E.D. Shortt, "Social Changes and Political Crisis in Rural Ontario: The Patrons of Industry, 1889–1896," in Donald Swainson, editor, *Oliver Mowat's Ontario* (Toronto, 1972), pp. 211-235. Beaton's comments appear in OSP, 1895, Volume 27, Pt. 2, No. 10, p. 170.

71 OSP, 1909, Volume 41, Pt. 10, p. 21.

72 Ontario, *Revised Statutes of Ontario,* 1877, XV, c. 220, paragraph 8.

73 *Ibid.*, paragraphs 12 and 17.

74 OSP, 1892, Volume 24, Pt. 1, No. 7, p. 5.

75 *Ibid.*, p. 24.

76 F.M. Powell, "The Feeble-Minded: Care of the Feeble-Minded," *Proceedings,* Twenty-Fourth National Conference of Charities (July 7-14, 1897) p. 291.

77 See Gerald Grob, *Mental Institutions in America* (New York, 1973), and David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, 1971).

78 Splane, pp. 49-50.

79 Andrew T. Scull, "Madness and Segregative Control: The Rise of the Insane Asylum," *Social Problems,* Volume 24, (February, 1977), p. 348.

80 See, for example, Howard S. Becker, "Moral Entrepreneurs," in Howard S. Becker, Editor, *Outsiders* (New York, 1963), and Lewis Anthony Dexter, "On the Politics and Sociology of Stupidity in Our Society," in Howard S. Becker, Editor, *The Other Side* (Glencoe, Illinois, 1964), pp. 37-49.

81 Rothman, p. 239.

82 The difficulty with applying the social control argument willy-nilly to an explanation of the rise of large institutions and to mental retardation policy is that it is often tautological. As Gareth Stedman Jones has pointed out:

> It is not difficult to demonstrate that a casual usage of "social control" metaphors leads to non-explanations and incoherence. There is no political or ideological institution which could not in some way be interpreted as an agency of social control. There is no indication in the phrase of who the agents or instigators of social control may be: no indication of any common mechanism whereby social control is enforced: no constant criterion whereby we may judge whether social control has broken down: certainly not conflict for this may ultimately or even inherently be a means of enforcing conformity. Nor finally is there any fixed yardstick whereby we may know when social control has been reimposed. Since capitalism is still with

us, we can with impunity suppose, if we wish to, that at any time in the last 300 years, the mechanisms of social control were operating efficiently.

Gareth Stedman Jones, "Class Expression versus Social Control," *History Workshop Journal*, No. 4, (Autumn, 1977), p. 163.

83 Board of Commissioners of Public Charities, *Fifteenth Annual Report, Pennsylvania Training School for Feeble-Minded Children*, 1885. In 1897 the Syracuse State Institution for Feeble-Minded Children admitted 59 and discharged 45 children. See State Commissions of the State of New York, *Thirtieth Annual Report of the Syracuse State Institution for Feeble-Minded Children*, 1897.

84 Peter Tylor and Jamil Zainaldin, "Asylum and Society: An Approach to Institutional Change," *Journal of Social History*, Volume 13 (Fall, 1979), p. 37.

85 F.M. Powell, pp. 290-291.

86 See *Journal of Psycho-Asthenics*, Volume 6 (March-June, 1902), p. 84.

87 OSP, 1881, Volume 13, Pt. 2, No. 8, p. 8.

88 John D. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (New Haven, 1975), p. 6.

89 Charles E. Rosenberg, p. 444.

Chapter 3

1 In the case of Dugdale's work this was a misinterpretation. He had distinguished between "hereditary and induced pauperism" in the Jukes family. "In the case of Fritz, we have an instance of induced pauperism stretching over several generations, because the organization of society keeps up a vicious mode of administering relief, and we have a case simulating hereditary pauperism, but only illustrating bad government." Dugdale also noted that it was still an open question as to the degree to which heredity or environment contributed to the formation of human character. See Richard L. Dugdale, "Hereditary Pauperism," in Gerald R. Clark and Marvin Kivitz, *The History of Mental Retardation, Collected Papers, Volume 1* (Baltimore, 1976).

2 Martin W. Barr, *Mental Defectives: Their History, Treatment and Training*, first edition 1904, republished by Arno Press (New York, 1973), p. 102.

3 See Helen Bousanquet, *Social Work in London, 1869–1912* (Brighton, Sussex, 1973, reprint of 1914 edition), p. 196. The term feeble-minded was used differently in England and in the United States. In the U.S. it referred to all mental defectives, whereas, in England it referred specifically to mental defectives above the grades of idiot and imbecile. The difficulty is, however, that the English tended to use the terms feeble-minded and mental defective interchangeably.

4 See Charity Organization Society, *The Feeble-Minded Child and Adult*

(London, 1893), p. 6 and Madelaine Rooff, *Voluntary Societies and Social Policy* (London, 1957), p. 192, n. 3.

5 Charity Organization Society, p. 32.

6 *Ibid.*, pp. 98-99, 141.

7 *Ibid.*, p. 54.

8 Herbert Davey, *The Law Relating to the Mentally Defective* (London, 1913), p. 322.

9 Gareth Stedman Jones, *Outcast London* (London, 1971), p. 286. According to Jones, the "casual poor" were those "minority of the still unregenerate poor: those who had turned their backs on progress, or had been rejected by it," p. 11.

10 *Ibid.*, p. 287, n. 14.

11 The *Times*, June 11, 1898.

12 The *Times*, May 7, 1903.

13 *Minutes of Evidence, Royal Commission on the Care and Control of the Feeble-Minded*, Volume 1, p. 169, 1908.

14 *Mental Deficiency Act*, 1913, (3 & 4 George 5. c. 28), Part I, Section 1.

15 *R.C. on Feeble-Minded*, Volume I, p. 61.

16 The reports of the medical investigators for the various sample districts, along with all relevant statistics, can be found in *R.C. on Feeble-Minded*, Volume VI, Part VI, Chapter XXIX, "General Statistics and the Reports of the Medical Investigators."

17 *R.C. on Feeble-Minded*, Volume VI, p. 218.

18 *Ibid.*, Volume VI. pp. 149-150.

19 See A.F. Tredgold, "The Feeble-Minded — A Social Danger," *Eugenics Review* 1, No. 1 (April, 1909), p. 100.

20 *R.C. on Feeble-Minded*, Volume VI, p. 221.

21 See *Report of the Proceedings of the National Conference on the Prevention of Destitution* (London, 1911), p. 630. W.H. Dickinson, a Liberal M.P., former Chairman of the National Association for the Care of the Feeble-Minded and an early supporter of legislation for the feeble-minded, stated at this conference: "With a few exceptions the pioneers of this movement [to help the feeble-minded] have been women guardians and women educationalists: and, for this simple reason, that in the personal attention that they devoted to the classes under their supervision, they came into actual contact with the evil as it existed and had set to work to devise a remedy."

22 *R.C. on Feeble-Minded*, Volume VI, p. 200.

23 *Ibid.*, Volume I, p. 497.

24 *Ibid.*, Volume VIII, p. 198.

25 *Ibid.*, Volume VIII, paragraph p. 553.

[26] *Minority Report, Royal Commission on the Poor Laws and Relief of Distress,* 1909, Part I, Chapter VI, p. 891. The Minority exaggerated here. The Royal Commission on the Feeble-Minded had estimated the total number of mental defectives at about 150,000. It was only when certified lunatics were added to this total that the total number of defectives could be estimated at 200,000. Moreover, the Minority was vague about whether both indoor and outdoor paupers constituted the "pauper host" of whom, they claimed, the mentally defective comprised one-sixth. If they meant all paupers, indoor and outdoor, the estimated 54,000 mental defectives were hardly one-sixth of the 761,000 total. Rather, the Minority must have meant that the estimated 42,000 mental defectives out of 230,000 indoor paupers was about one-sixth, or 18.19 percent according to the figures of the Royal Commission. Whatever the Minority meant, however, there is little doubt they wished to exaggerate the number of mental defectives among the paupers so they could support their argument that the Poor Laws had caught in its tentacles people whose problems could never be solved without creating institutions outside the Poor Law system.

[27] The *Times,* November 7, 1910.

[28] See Kathleen Jones, *A History of the Mental Health Services* (London, 1972), pp. 196-7.

[29] See *Eugenics Review,* Volume 2, No. 3 (October 1910), pp. 163-4.

[30] House of Commons, *Debates,* June 10, 1912, p. 664.

[31] *Ibid.,* May 17, 1912, p. 1464.

[32] *Ibid.,* July 28, 1913, p. 147.

[33] *Ibid.,* May 17, 1912, p. 1472.

[34] *Ibid.,* p. 1463. Over the years eugenics has been associated with right-wing political views and, during World War II, with the worst excesses of Fascism. Even today because of its apparent linkage with the hereditist argument in the IQ controversy, it is still associated with conservative or reactionary ideas. Yet, during the late nineteenth and early twentieth centuries people such as Sidney and Beatrice Webb, Harold Laski and even Richard Titmuss saw no contradiction between socialism and eugenics. As Michael Freeden has pointed out: "For many, it was a new and worthwhile experiment in the field of social reform — a field which in the first half of this century invited and encouraged innovations in ideas and practices. For a few, its aims appeared to be socialist ones and . . . many of its fundamental precepts were shared with socialism." M. Freeden, "Eugenics and Progressive Thought: A Study in Ideological Affinity," *The Historical Journal,* Volume 22 (1979), p. 670.

[35] House of Commons, *Debates,* May 28, 1913, p. 236.

[36] *Ibid.,* May 17, 1912, p. 1468.

[37] *Mental Deficiency Act,* 1913, Part I, Section 1, (c).

[38] J. Wormald and S. Wormald, *A Guide to the Mental Deficiency Act of 1913* (London, 1913), p. 83.

Chapter 4

1 OSP, 1907, Volume 39, Pt. 9, *Report of the Inspector of the Feeble-Minded,* No. 1, (hereafter referred to as *IFM*) pp. 4-5.

2 Public Archives of Canada, *National Council of Women,* mimeographed article, no date.

3 Emily Cummins, "The Problem of the Feeble-Minded," *National Council of Women,* mimeographed article, no date.

4 *Ibid.*

5 *National Council of Women,* unsigned letter to Mrs. Nisbet, February 27, 1913. On the activities of the National Council of Women in relation to the feeble-minded see Veronica Strong-Boag, *Parliament of Women: The National Council of Women of Canada: 1893-1929* (Ottawa, 1976), pp. 202 *et passim.*

6 OSP, 1915, Volume 47, Pt. 1, No. 1.

7 *Ibid.*, 1916, Volume 48, Pt. 1, No. 1.

8 Howard S. Becker, *Outsiders, op. cit.*, pp. 147-148. Dr. MacMurchy never married, but she apparently had a brief love affair with Marie Stopes, the English birth control advocate, who visited Canada in 1909. They exchanged passionate love letters during the early months of 1909 after Stopes left Toronto, but the affair subsequently lapsed. Dr. MacMurchy was one of the guests at Stopes' wedding to Reginald Gates in Montreal on March 18, 1911. See Ruth Hall, *Marie Stopes* (London, 1977), pp. 77-80, and 92.

9 OSP, 1912, Volume 44, Pt. 8, pp. 3-5.

10 *Ibid.*, 1907, Volume 39, Pt. 9, *IFM* No. 1, p.7.

11 *Ibid.*, p. 8.

12 *Ibid.*, p. 10.

13 *Ibid.*, p. 4.

14 Ontario, *Revised Statutes of Ontario,* 1877, c. 220, Title XV Schedule No. 1.

15 *Ibid.*, Section 12.

16 OSP, 1881, Volume 13, Pt. 2, No. 8, p. 26.

17 *Revised Statutes of Ontario,* 1877 Schedule No. 2.

18 *Academy of Medicine,* "Symposium on the Feeble-Minded," November 31, 1916, p. 12.

19 OSP, 1912, Volume 42, Pt. 6, *IFM*, No. 4, p. 3.

20 *Ibid.*, pp. 5-7.

21 *Globe,* March 18, 1909.

22 *Mail,* March 11, 1911.

[23] OSP, 1912, Volume 44, Pt. 8, *IFM*, No. 6, p. 7.

[24] City Hall, *Minutes*, April 9, 1912, Appendix A.

[25] *Ibid.*

[26] *Globe*, May 14, 1912.

[27] See Wayne Roberts, "Six New Women," *Atlantis* Volume 3 (Fall, 1977), pp. 145-164.

[28] *World*, November 9, 1912.

[29] *Ibid.*

[30] Ontario, 1912 *Statutes*, 82..

[31] *Ibid.*, 1913, c. 76.

[32] *Ibid.*, 1919, c. 84.

[33] OSP, 1915, Volume 47, Pt. 8, No. 24, *IFM*, No. 9, p. 15.

[34] *Ibid.*, 1919, Volume 51, Pt. 5, No. 23, p. 29.

[35] *Ibid.*, 1920, Volume 52, Pt. 5, No. 23, p. 1.

[36] Mrs. Adam Shortt, M.D., "An Old Text," in *The Public Health Journal* Volume 5 (April, 1914), pp. 227-228.

[37] OSP, 1907, Volume 39, Pt. 9, No. 63, *IFM*, No. 1, p. 7.

[38] *Ibid.*, 1908, Volume 40, Pt. 9, No. 62, *IFM*, No. 2, p. 13.

[39] Cited in Gerald T. Hackett, *The History of Public Education of Mentally Retarded Children in the Province of Ontario, 1867–1964, D. Ed., University of Toronto, 1969.*

[40] Ontario, *Statutes*, 1911, c. 78.

[41] OSP, 1914, Volume 46, Pt. 8, No. 23, *IFM*, No. 8, p. 68.

[42] Public Archives of Ontario, W.J. Hanna file.

[43] *Ibid.*, "Report of the Advisory Committee on the Care of the Feeble-Minded in Toronto," Presented to the Provincial Secretary by His Worship the Mayor of Toronto and the Board of Control.

[44] OSP, 1912, Volume 44, Pt. 8, No. 23, *IFM*, No. 6, p. 63.

[45] *Ibid.*, 1910, Volume 42, Pt. 6, No. 23, *IFM*, No. 4, p. 8.

[46] *Ibid.*, 1910, Volume 42, Pt. 6, No. 23, *IFM*, No. 4, p. 4.

[47] *Public Health Journal*, "Symposium on the Feeble-Minded," (December 1, 1916).

[48] *Telegram*, December 1, 1916.

[49] OSP, 1916, Volume 48, Pt. 8, No. 24, *IFM*, No. 10, p. 6.

[50] C.K. Clarke Archives, C.K. Clarke to N.W. Rowell, April 27, 1916, Clarke

Institute, Toronto.

51 *Ibid.*, Memo, December 14, 1916.

52 *Ibid.*, W.D. Gwynne to C.K. Clarke, undated, circa March, 1917.

53 Provincial Archives of Ontario, Hearst to McPherson, January 27, 1917.

54 *Ibid.*

55 OSP, 1913, Volume 45, Pt. 7, No. 23, p. 32.

56 PAO, McPherson to MacMurchy, Memo, February 9, 1917.

57 PAO, W.D. McPherson files, "Notes of Deputation re Feeble-Minded." T. Bradshaw had a remarkable career, rising to become President of the North American Life Assurance Company and a director of numerous other companies. Interestingly enough, contemporary newspaper accounts characterize Bradshaw as a kindly man, always willing to do favours for the poor or the unfortunate. Whatever the reasons, Bradshaw is one of the few people on record who opposed plans to institutionalize mentally retarded people.

58 PAO, C.K. Clarke to Hearst, May 1, 1917.

59 Martin W. Barr, *Mental Defectives: Their History, Treatment and Training* (New York, 1973, reprint of 1904 edition), p. 260.

60 Cited in Barr, p. 85.

61 Barr, p. 129.

62 George S. Strathy, "The Feeble-Minded and Social Evils," *The Public Health Journal*, Volume 5 (April, 1914), pp. 232-233.

63 Great Britain, *Royal Commission on the Care and Control of the Feeble-Minded*, XXXV, Volume 1, question no. 2398.

64 Dr. Clare Hincks seems to have first learned about the Binet test at a meeting in Buffalo, New York. Dr. MacMurchy, however, remained suspicious of IQ tests as a sole guide to mental retardation, and continued to rely for a long time on general physical examination and intellectual assessment carried out by physicians. See Hackett, pp. 103-104.

65 Strathy, p. 233.

66 E.R. Johnstone, "Waste Humanity," *Public Health Journal*, Volume 5 (April, 1914), p. 209.

67 Lucy M. Brookings, "We Pay," *Public Health Journal*, Volume 5 (April, 1914), p. 212.

68 C.K. Clarke, "General Considerations," paper read to Academy of Medicine, December 1, 1916.

69 See Reports of Inspector of the Feeble-Minded, Nos. 3, 5 and 6.

70 OSP, 1916, Volume 48, Pt. 8, No. 24, *IFM*, No. 10, p. 37.

71 *Ibid.*, 1909, Volume 41, Pt. 10, No. 58, *IFM*, No. 3, p. 4.

72 Dr. H.L. Brittain, "Feeble-Mindedness," *Public Health Journal,* December 1, 1916, p. 1.

73 OSP, 1909, Volume 41, Pt. 10, No. 58, *IFM*, No. 3, p. 10.

74 OSP, 1880, Volume 13, Pt. 2, No. 8, p. 7.

75 *Ibid.*, 1908, Volume 40, Pt. 9, No. 60, *IFM*, No. 2, p. 15.

76 See *Journal of Pyscho-Asthenics,* Volume 8 (1904).

77 See Ellen Legarde, "Should the Scope of the Public School be Broadened to Take in All Children Capable of Education? *Journal of Pyscho-Asthenics,* Volume 8 (1904), p. 38.

78 OSP, 1907, Volume 39, Pt. 9, No. 63, *IFM*, No. 1, p. 16.

79 *Ibid.*, 1911, Volume 43, Pt. 6, No. 25, p. 146.

80 *Ibid.*, p. 52.

81 *Ibid.*, 1912, Volume 44, Pt. 8, No. 23, p. 17.

82 Helen MacMurchy, "Can the Mentally Defective Child be Educated in the Public Schools?" *International Congress on Social Hygiene, Fourth International Congress,* Volume 3 (1913), p. 489.

83 *Ibid.*, p. 491.

84 See Hackett, Appendices.

85 OSP, 1920, Volume 52, No. 24, pp. 1-137. Hereafter referred to as Hodgins.

86 Hodgins, pp. 39-41.

87 Quoted in Hodgins, p. 62.

88 Quoted in Hodgins, p. 39.

89 PAO, W.D. McPherson, Correspondence, 1916–1919.

90 Hodgins, pp. 100 and 123.

91 Hodgins, p. 60.

92 Hodgins, p. 20.

93 Hodgins, p. 4.

94 Hodgins, p. 5.

95 Hodgins, pp. 126-127. An article in the February, 1916 *Health Bulletin* issued monthly by the Department of Health of the City of Toronto gives some idea of how seriously this idea was taken. It was called: "Is the Mentally Defective a Problem in Preventive Medicine?" The article consisted of the usual statistics linking mental deficiency to crime and other social problems as well as explaining the hereditary nature of the condition.

96 Hodgins, p. 11.

97 Hodgins, p. 12.

98 Hodgins, p. 60.

99 Hodgins, p. 98.

100 Hodgins, p. 130.

101 Hodgins, p. 131.

102 Hodgins, p. 131.

103 Charles G. Roland, *Clarence Meredith Hincks, M.D. 1885–1964: A Biography,* Archives, Canadian National Committee for Mental Hygiene, pp. 76 and 79.

104 Ontario, *Statutes,* 1913, c. 76.

105 C.M. Hincks, "Governments and the Feeble-Minded," a speech to the Social Welfare Congress, January 14, 1919. Archives, Mental Health Canada.

106 Ontario, *Statutes,* 1911, c. 32, sec. 17 added a prison sentence of not more than twelve months to the $500 penalty first imposed in the 1896 Marriage Act on those issuing marriage licenses to the idiotic or insane.

107 See OSP, 1920, Volume 52, Pt. 5, No. 24 *IFM,* No. 14, p. 21.

108 *Ibid.,* 1897/98 Volume 30, Pt. 3, No. 10, p. 240.

109 *Ibid.,* 1903, Volume 35, Pt. 8, No. 48, p. 163.

110 *Ibid.,* 1918, Volume 50, Pt. 6, No. 23, p. 28.

111 *Ibid.,* 1897/98 Volume 30, Pt. 3, No. 10, p. 237.

112 *Ibid.,* 1914, Volume 46, Pt. 8, No. 23, p. 27.

113 *Ibid.,* p. 31.

114 *Ibid.,* 1918, Volume 50, Pt. 6, No. 23, p. 30.

115 Quoted in Janet Shea, p. 116.

116 A.H. Beaton, *A.H. Beaton's Letter Books,* Provincial Archives of Ontario.

117 OSP, 1903, Volume 35, Pt. 8, No. 38, pp. 164-165.

118 *A.H. Beaton's Letter Books,* Beaton to MacDonald, June 1, 1907.

119 OSP, 1924, Volume 56, Pt. 5, No. 22, p. 15.

120 Ontario Legislative Assembly, *Journals,* 1937, Volume 71, p. 183 gives the statistics for the fiscal years from October 31, 1932 to March 31, 1936.

121 OSP, 1926, Volume 58, Pt. 4, No. 15, p. 11.

122 *Ibid.,* 1922, Volume 54, Pt. 5, No. 22, p. 122.

123 *Ibid.,* 1923, Volume 55, Pt. 5, No. 22, p. 119. There was evidently some trade union resistance to attempts by the asylums to sell their products on the open market. Dr. C.K. Clarke complained of this in 1922: "It was unfortunate that we were restricted in the sale of our output as the kings of labour

[*sic*] had not given up their ideas of the identity of prison and asylum labour. We were forced to get rid of a great many of our products either in the Province of Quebec or in supplying the other institutions in Ontario with brushes, brooms, etc." See "Statement of Dr. C.K. Clarke re Occupational Therapy in Ontario Hospitals for the Insane," January 13, 1922, Archives, CNCMH.

124 F.S. Burke, "The Administrative Control of the Diptheria Toxoid Campaign in Toronto," *Canadian Public Health Journal*, Volume 21 (May, 1930), pp. 209-218. Burke also notes: "The Health Department [of Toronto] in keeping with their policy throughout all school work, required written consent from the parent of the child before testing or immunizing." In a 1980 interview the parent of a mentally retarded person told me she strongly suspected drug companies had given authorities at the big institutions tranquilizers to be tested on the residents without authorization from the parents or Guardians. She also claimed that her son had been the subject of unauthorized experiments on sexual behaviour during the 1960's.

125 Ontario, *Statutes*, 1903, c. 38.

126 *Ibid.*, 1913, c. 82.

127 See F.A. Allodi, and H.B. Kedward, "The Evolution of the Mental Hospital in Canada," *Canadian Journal of Public Health*, Volume 68 (May/June, 1977), p. 220.

128 OSP, 1917, Volume 49, Pt. 6, No. 25, p. 23.

129 *Ibid.*, 1910, Volume 42, Pt. 6, No. 24, p. 15.

130 OSP, 1912, Volume 44, Pt. 8, No. 25, p. 17.

131 David Braybrook and Charles E. Lindblom, *A Strategy for Decision* (New York, 1976), p. 102.

132 Georg Simmel, "The Poor," in John Harp and John R. Hofley, *Poverty in Canada* (Scarborough, Ontario, 1971), p. 52.

Chapter 5

1 Fernald quoted in Hodgins, p. 40.

2 C.M. Hincks, "Recent Additions to Our Knowledge of Mental Deficiency," *Social Welfare*, Volume 7 (February, 1925), pp. 91-93.

3 On this campaign see, Freida Held, *A Brief History of the Ontario Welfare Council, 1908-1959 (Toronto, 1959)*. It is worth noting that in the committee report published in the May, 1926 issue of *Social Welfare*, the committee did not "endorse sterilization policy. . . ," that it felt "methods of community supervision have not been well enough defined to allow formation of any opinion as to its value. . ." and that it felt it "very wise" that child placement agencies did not "encourage legal adoption of defectives." For the report see *Social Welfare*, Volume 8 (April, 1926), pp. 137-146 and Volume 8 (May, 1926), pp. 168-174.

4 Held, p. 9.

5 D.G. McKerracher, "Trends in Psychiatric Care," in Canada, *Royal Commission on Health Care*, 1962, p. 6. Also see R.R. MacLean and E.J. Kibblewhite, "Sexual Sterilization in Alberta," *Canadian Public Health Journal*, Volume 28 (December, 1937), pp. 587-590 and Great Britain, *Report of the Departmental Committee on Sterilization*, June 9, 1932, Cmnd. 4485.

6 Helen MacMurchy, *Sterilization? Birth Control?* (Toronto, 1932).

7 Cited in MacMurchy, pp. 24 and 26.

8 PAO, Hepburn Correspondence. The file contains only a few documents on sterilization sent by the Eugenics Society to Hepburn prior to their visit. Among them is a copy of the Brock Report and some charts showing how mental deficiency was passed on within families. There are also some notes of thanks to the Premier from various members of the Society including one from Rabbi Maurice Eisendrath of Holy Blossom Temple Toronto. In a letter the Rabbi quotes approvingly from the 1927 U.S. Supreme Court decision upholding a Virginia sterilization law. In the landmark case Justice Holmes made his famous statement that "the principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough." Rabbi M. Eisendrath to Hepburn, February 5, 1934.

9 Quoted in MacMurchy, p. 16.

10 I once heard Bruno Bettelheim in a lecture claim that such fears did act as a restraint on people of his generation.

11 Dr. C.B. Farrar, "Sterilization and Mental Hygiene," *Canadian Public Health Journal* (February, 1931), pp. 92-94.

12 *Report of the Departmental Committee on Sterilization*, p. 18.

13 *Ibid.*, p. 21.

14 *Ibid.*, p. 14.

15 Ontario, *Report of the Royal Commission on Public Welfare*, August 13, 1930, pp. 9 and 44.

16 OSP, 1929, Volume 61, Pt. 3, No. 11, *Report of the Inspector of Auxiliary Education*.

17 *R.C on Public Welfare*, pp. 31-32, 41-43.

18 *Ibid.*, p. 107.

19 Nova Scotia, *Report of the Royal Commission Concerning Mentally Deficient Persons in Nova Scotia*, 1927, pp. 42-43.

20 Alberta, *An Act Respecting Mentally Defective Persons*, cap. 21, 1919.

21 Quoted in Hackett, p. 160. From the very inception of special education for mentally retarded children, education authorities seem to have been much more sympathetic towards them, and protective of their interests than those associated with the institutions. In the 1916/17 edition of the *Journal of Psycho-Asthenics*, two articles were run side by side and illustrate the differ-

ence in attitude. One, by Dr. George Bliss, the superintendent of the Indiana School for Feeble-Minded Youth was entitled, "The Danger of Classifying as Merely Backward Children who are Feeble-Minded." Here the author warns of the "so-called moron type of mental defect. They are so bright apparently to the casual observer and to the untrained social worker that they are seldom classed as defective . . ." But, the author argues: "Those not informed will hardly ever believe the kind of immoral acts, and the sort of antisocial conduct that is possible with such an individual. His absolute untruthfulness rivals that of the opium eater; his respect for property exists only as long as he is under observation. Individuals of this class are always egotistical and vain, loving fine clothes, yet never careful of them . . ." The following article by Dr. J.M. McCallie, Dirctor of special classes in Trenton, New Jersey was called "Dangers of Classifying as Feeble-Minded Children who are Merely Backward." Here the author points out that the various authorities disagree profoundly on the question of how to properly distinguish between the backward and feeble-minded and he quotes a "sociologist" who warns that "to call a merely backward child feeble-minded [is] a crime against the child . . . but to have to carry the stigma of being feeble-minded with the burden of being backward throughout life [is] intolerable." *Journal of Psycho-Asthenics,* Volume 21 (September and December, 1916/17), pp. 43-45 and 52-57.

22 OSP, 1926, Volume 58, Pt. 3, No. 11, *Report of the Inspector of Auxiliary Classes,* Appendix G, p. 47.

23 *Ibid.*, 1928, Volume 60, Pt. 3, No. 11, p. 45.

24 *Ibid.*, 1932, Volume 64, Pt. 3, No. 11, p. 38.

25 Quoted by Hackett, p. 160.

26 Interview with L.H. DeLaporte.

27 OSP, 1929, Volume 61, Pt. 3, No. 11, p. 136.

28 *Ibid.*, p. 13.

29 Hackett, p. 164. In that same year, aided by Helen DeLaporte, the Assistant Inspector of Auxiliary Classes, Sinclair trained inspectors who in turn, trained individual teachers to administer the tests.

30 See Hackett, p. 175.

31 B.T. McGhie and E.D. MacPhee, *Training and Research in a Hospital for Subnormals,* Ontario Hospital (Orillia) Publications, Volume 1, No. 1 (February, 1929), pp. 9 ff.

32 *Ibid.*, p. 10.

33 B.T. McGhie, "Amentia — An Economic, Educational, Social and Public Health Problem" *Canadian Public Health Journal,* Volume 22 (January, 1931), pp. 5-9.

34 ————, "The Problem of the Subnormal in the Community," in *Ibid.*, Volume 28 (March, 1937), pp. 106-109.

35 Interview with Professor C.R. Myers.

36 McGhie, "The Problem of the Subnormal in the Community," pp. 110-111.

37 See Dr. Thomas Haines, "Community Service of State Institutions for the Mentally Defective," *Journal of Psycho-Asthenics*, Volume 28 (1923), pp. 39-50.

38 Z. Pauline Hoakley, "Extra-Institutional Care for the Feeble-Minded," in *Ibid.*, Volume 27 (1922), pp. 117-137.

39 Interview with Professor C.R. Myers.

40 OSP, 1929, Volume 61, Pt. 4, No. 15, p. 10.

41 Quoted in Janet Shea, p. 158.

42 On the Colony House see Marion E. Haugh, *A Survey of the Girl's Probation Scheme at the Ontario Hospital, Orillia, in Regard to Success or Failure,* MS. Submitted to the Department of Social Science, University of Toronto, May 18, 1933, 21 pages.

43 For a report on the Haven, see A. Mildred Jeffrey, "A Follow-Up Study in the Re-Establishment of Mentally Defective Girls in Domestic Science in an Urban Centre under Colony House Supervision," *American Journal of Mental Deficiency,* Volume 48 (July, 1943), pp. 96-100.

44 OSP, 1932, Volume 64, Pt. 4, No. 15, p. 19.

45 *Ibid.*, 1938, Volume 70, Pt. 4, No. 15, p. 14.

46 On the boarding-out program in the mental hospitals, see C.A. Buck, "Rehabilitation of the Mentally Ill," *Canadian Public Health Journal,* Volume 31 (January, 1940), pp. 62-67.

47 On the goals of the clinic plan, see PAO, Howard Ferguson file, letter to Ferguson from B.T. McGhie, February 22, 1930.

48 Ontario, Department of Health Archives, letter from Dr. C.R. Myers to Dr. J.T. Phair regarding a conference of Mental Health Clinic Directors, Toronto, December 27, 1940.

49 Interview with J. Boyd.

50 B.T. McGhie, "The Development of a Provincial Mental Health Service," *Canadian Public Health Journal,* Volume 24 (January, 1933), p. 10.

51 Interview.

52 B.T. McGhie, "The Problem of the Subnormal in the Community," p. 111.

53 B.T. McGhie, "The Development of a Provincial Mental Health Service," p. 11.

54 *Ibid.*, p. 14.

55 OSP, 1947, Volume 79, Pt. 3, No. 15, pp. 15-16.

56 Ontario, *Royal Commission on the Operation of the Mental Hospital Act,* 1938, Clifford Magone, Chairman; W.H. Avery and Lionel Conacher, Commissioners.

[57] *Ibid.*, p. 57.

[58] *Ibid.*, p. 49.

[59] PAO, memorandum from Deputy Minister of Public Works to George Hogarth, Architect's Office, July 12, 1934.

Chapter 6

[1] Simmel, p. 52.

[2] See *Journal of Psycho-Asthenics*, Volume 10, (1906), p. 208.

[3] *Ibid.*, p. 110.

[4] Simmel, p. 52.

[5] C.K. Clarke Archives, Clarke Institute. C.K. Clarke to N.W. Rowell, April 27, 1916.

[6] See P.B. Waite, "Sir Oliver Mowat's Canada: Reflections on an Un-Victorian Society," in Donald Swainson, editor, *Oliver Mowat's Ontario*, (Toronto, 1972), p. 15.

[7] Terence Morrison in his unpublished Ph.D. Thesis, "The Child and Urban Social Reform in Late Nineteenth Century Ontario," notes the middle class nature of the child reform movement in Ontario. University of Toronto, 1971, pp. 458 ff.

[8] Hodgins' suggestion was probably inspired by the example of the English Board of Control which had grown out of the 1913 Mental Deficiency Act and included members from various English voluntary societies. It directly inspired the formation of the Central Association for the Care of the Mentally Defective in 1913 which included members from local government, asylums and various pressure groups. Among its tasks, the Central Association undertook to keep records of the local associations and to keep a register of mentally retarded people moving from one area to another. See Madelaine Rooff, *Voluntary Societies and Social Policy* (London, 1957), pp. 105 ff.

[9] Ontario, Department of Health, *A Survey of Ontario Hospitals* conducted in February, 1937 by the Hospital Survey Committee. The members were Samuel W. Hamilton, formerly Medical Director, Bloomingdale Hospital, and Dr. G.A. Kempf, member of the staff of the U.S. Public Health Service.

[10] *Ibid.*, pp. 3, 13-15.

[11] *Ibid.*, p. 18.

[12] *Ibid.*, p. 41.

[13] Interview.

[14] At least two people interviewed who had extensive experience in the field and who were acquainted with some of the staff at Orillia claimed that for a long time a high percentage of the "professionals" were either unqualified

or poorly qualified for their jobs. Often this was because they could not get better jobs, while the low pay scale at Orillia and other institutions was unlikely to attract the best people in the field. Sometimes the reason may have been that an appointment at Orillia was a reward for political activities in support of the governing political party.

15 OSP, 1935, Volume 67, Pt. 4, No. 15.

16 See Ontario, Department of Health, report on patients in residence in Ontario Hospitals and Hospital Schools, 1937–1960, *41st Annual Report*, 1965.

Chapter 7

1 See W. Newland Reilly, "Let the Parent Live Again," *American Journal of Mental Deficiency*, Volume 46 (1941/42), pp. 409-413. Also see Herbert J. Lerner, *State Association for Retarded Children and New York State Government, 1948–1968* (New York, 1972), pp. 36-39.

2 Interview with R.G. Anglin.

3 Hackett, p. 352.

4 Betty Anglin, *History of the Metro Toronto Association for Retarded Children*, in archives of Ontario Association for the Mentally Retarded, p. 4.

5 Ontario Legislature, *Debates*, March 29, 1949.

6 *Ibid.*

7 *Debates*, March 15, 1951.

8 *Ibid.*, March 28, 1960, p. 1830.

9 *Ibid.*, March 21, 1961, p. 2387.

10 *Ibid.*, p. 2388.

11 Ontario Association for Retarded Children, *Annual Report of the Education Committee, 1962, p. 2.*

12 *Debates*, March 26, 1963.

13 Interview with J. Haddad.

14 RSO, 1970, c. 425.

15 See Fred Schindeler, *Responsible Government in Ontario* (Toronto, 1969) Table 2, p. 20 and D.K. Foot, *Provincial Public Finance in Ontario: An Empirical Analysis of the Last Twenty-Five Years* (Toronto, 1977) p. 15.

16 See Lerner, pp. 121 and 317.

17 According to R.G. Anglin who was OAMR President from 1962 to 1964, Minister of Education Davis was extremely helpful in getting the transfer through. Says Anglin: "I feel Davis did much to push his education chiefs towards the eventual takeover of the MR schools."

18 Ontario Association for the Mentally Retarded, *Position Paper on the Fu-*

ture Role of the OAMR, September, 1976, p. 5.

19 Quoted in Kathleen M. Slack, *Social Administration and the Citizen* (London, 1966), p. 20.

20 Robert Pinker, *Social Theory and Social Policy* (London, 1973), p. 170.

21 *Future Role Report*, No. 2, p. 13.

22 Simmel, p. 52.

Chapter 8

1 Ontario Legislative Assembly, 1935, *Journal* Volume 59, pp. 113-114 and 1943, Volume 77, p. 48. Mr. and Mrs. Anglin were told that the plans for Smiths Falls were originally drawn up for a proposed mental hospital in Thunder Bay or Sault-Ste-Marie, but that they were ultimately used for Smiths Falls. Mrs. Anglin claims that she saw the original plans for the Midwestern Regional Centre at Palmerston and learned that they were patterned after the Mansfield institution in Connecticut. The plans were dated 1939.

2 Wolf Wolfensberger, *The Origin and Nature of our Institutional Models* (Syracuse, 1975), p. 8.

3 Ernest L. Roselle, "Connecticut's New Institution for Mental Defectives Dedicated," *American Journal of Mental Deficiency*, Volume 45(1940), p. 465.

Ontario, Department of Health, *Report of the Ontario Health Survey Committee*, 1952, p. 110.

5 *Debates*, March 23, 1955.

6 *Ibid.*, March 27, 1956.

7 *Ibid.*, February 24, 1958.

8 See Alex Richman, M.D., "Psychiatric Care in Canada: Extent and Results," in Canada, *Royal Commission on Health Services*, 1966, Table 12-14.

9 See A. Miller, "The Changing Mental Hospital," in *Canadian Hospital*, Volume 37 (February, 1960), pp. 39-41, 94.

10 *Debates*, March 17, 1958.

11 *Ibid.*

12 For a comparative perspective see D. Baumstein, "Services to the Mentally Retarded: A Brief Survey in Contrasts between Great Britain and the U.S.," *American Journal of Mental Deficiency*, Volume 62 (1957/58), pp. 405 ff.

13 W.G. Brown and B.H. McNeel, *Proposed Revision of Mental Health Program in Ontario*, Ontario, Department of Health Archives, January, 1959.

14 *Debates*, February 11, 1959. For the first time, the Department of Health consulted some of their staff on proposed construction and because of their

objections, the proposed Cedar Springs institution was reduced in size. The OAMR had heavily lobbied for the research centre in briefs to the government. Ultimately it took the form of CPRI in London.

15 Toronto *Star*, January 8, 1960.

16 According to Lloyd Leatherby, PC: "It is no secret that there is overcrowding at the hospital in Orillia and neither is it any secret that there is considerable overcrowding in every general hospital in the province. *Debates*, February 12, 1960.

17 *Debates*, February 12, 1960. According to Dr. John D. Griffen the former head of the Canadian Mental Health Association, the organization Mr. Trotter referred to was the World Federation on Mental Health and the information came from preliminary reports of the Tyhurst Commission which in 1963 published their final report as *More for the Mind*.

18 *Ibid.*, March 14, 1960.

19 *Ibid.*

20 *Debates*, March 14, 1960.

21 See Ontario Association for Retarded Children, "Pressing Mental Retardation Problems: A Brief to the Honourable Leslie M. Frost and Members of the Cabinet, Province of Ontario, December, 1958." OAMR archives.

22 Interview with R.G. Anglin.

23 *Debates*, December 5, 1960.

24 Interview.

25 See, for example, Betty Anglin and June Braaten, *Twenty-Five Years of Growing Together: A History of the Ontario Association for the Mentally Retarded,* Canadian Association for the Mentally Retarded, 1978. According to the authors: "For the past five years [since 1958] the Institutions Committee had been urging the building of smaller, less isolated institutions and higher staff ratios (p. 34)." This may have been true of the Institutions Committee but quite clearly the OARC brief presented to Cabinet in 1960 urged the building of 1,000-bed institutions.

26 According to Anglin and Braaten, as early as 1959 the Institutions Committee of the OARC which was composed of members from both the OARC and government institutions met with Bert Schmickel of the Southbury Training School in Connecticut "to talk about the advantages of small cottages over large dormitories."

27 *Debates*, March 14, 1960.

28 Interview with Dr. M. Dymond.

29 On the distinction between "residual" and "institutional" social services, see H.L. Wilensky and C.N. Lebaux, *Industrial Society and Social Welfare* (New York, 1965), pp. 138 ff.

30 The members of the committee were: H.R. Beattie, Superintendent of Special Services and W.K. Clarke, Assistant Superintendent of Special Services

Department of Education; Cyril Greenland, Social Work Advisor and Dr. C.H. Lewis, Assistant Director, Ontario Hospitals Department of Health; and, Jack Amos, Director, Rehabilitation Services Branch and Dr. H.V. Cranfield, Medical Advisor, Rehabilitation Services Branch, Department of Public Welfare. The Committee was chaired by Dr. B.H. McNeel, Chief of the Mental Health Branch from the Department of Health. On this committee, see *Debates,* December 13, 1962.

31 Ontario, Department of Health, *Report of the Interdepartmental Committee on Mental Retardation,* August, 1963.

32 Great Britain, *Better Services for the Mentally Handicapped,* (London, 1959), Cmnd. 4683.

33 *Interdepartmental Committee on Mental Retardation,* pp. 2-8.

34 C.A. Roberts, *A Report on Ontario's Mental Health Services,* Ontario, Department of Health, 1963. According to R.G. Anglin Roberts' name had been suggested by the OARC.

35 *Ibid.*, pp. 20, ff.

36 *Ibid.*, p. CR-15.

37 C.A. Roberts, p. CR-3.

38 *Ibid.*, p. CR-44.

39 *Ibid.*, p. CR-46.

40 B.H. McNeel, *Brief on Departmental Programming for Mentally Retarded,* Ontario, Department of Health, Mental Health Branch, in C.A. Roberts, 1963.

41 *Debates,* October 22, 1979.

42 C.A. Roberts, p. CR-83.

43 Although one Department of Health official interviewed claimed that little effort was made to actually collect maintenance costs from either the patients or their families while the patients were in the residential units.

44 C.A. Roberts, p. CR-83.

45 Michel Foucault, *Madness and Civilization* (New York, 1973), p. 270.

46 According to G.R. Weller: "An analysis of the health field reveals that there are two major paradigms and that most policy initiatives in Canada in the past decades have taken place within the confines of only one of them. They can be symbolized by the difference between preventative and curative medicine.

"Curative medicine is individualistic, aimed primarily at curing individuals. It is represented by the services delivered by doctors in hospitals. Treatment by drugs also became associated with this type of care because it was the doctor who, by and large, acquired the right to administer drugs.

"Until recently, the conventional wisdom, or paradigm, about curative care, has provided the common intellectual structure for policy analysis in health and this has determined the parameters of the problems perceived and

their resolution. This 'ideology' has been a vital determinant of Canadian health policy. . . ." "The Determinants of Canadian Health Policy," in *Journal of Health Politics, Policy and Law,*" Volume 5 (Fall, 1980), p. 408.

Chapter 9

1 Interview with R.G. Anglin.

2 The members of the group which wrote the paper were: Jack Amos, Department of Public Welfare; W.K. Clare, Department of Education; W.R. Kirk, Ontario Association for Retarded Children; F.H. Potts, Department of Reform Institutions; Cyril Greenland, Department of Health; and, Dr. Donald E. Zarfas, Department of Health and Chairman of the Committee.

3 It was only in 1980 that a corporation, the Metro Toronto Association for the Mentally Retarded was for the first time appointed Guardian for a mentally retarded person. See *Globe and Mail*, June 16, 1980.

4 The Coordinating Committee was composed of Jack Amos, C.K. Clarke, Dr. Jean Moore, W.R. Kirk, Cyril Greenland and D.E. Zarfas, Chairman.

5 See D.E. Zarfas, "Moving Toward the Normalcy Principle in a Large Government Operated Facility for the Mentally Retarded," *Journal of Mental Subnormality,* Volume 16 (December, 1970), pp. 84-92.

6 See Joseph W. Willard, *Inquiry into the Management and Operation of the Huronia Regional Centre, Orillia: A Report to the Honourable James Taylor, Minister of Community and Social Services,* November, 1976.

7 *Debates,* June 7, 1965.

8 *Ibid.*, June 15, 1965.

9 Lerner, pp. 205 and 211.

10 Quoted in *Debates,* February 25, 1964 by Liberal MPP Vern Singer.

11 Interview.

12 Denis Lazure, M.D., *Report, Mental Retardation in Canada,* Department of National Health and Welfare, Ottawa, Federal-Provincial Conference, Ottawa, October 19-22, 1964, p. 72. Skepticism about the effectiveness of interdepartmental committees seems to be widespread. Donald Schon writes: "I have participated in about six inter-agency committees with durations of one year or more, and as a matter of interest have enquired of other individuals who have participated in them, whether anyone has been a member of such a committee which was effective in carrying out the functions assigned to it. I have never received an affirmative answer. The committee may make a show of performance during the early stages of its operation and particularly if it is subject to some strong external threat. . . . But, shortly, usually within a matter of months, the principle forces at work appear to be those of individual agency baronies and the demands of territoriality. The actual, as opposed to the official agenda, becomes that of assuring and protecting the territorial interests of each agency, rather than that of cooperatively attacking the problems which lie in inter-agency space." See Donald

Schon, *Beyond the Stable State* (London, 1971), p. 167.

13 Canada, *Royal Commission on Health Services,* Volume I, 1964, p. 24.

14 *Debates,* May, 3, 1966. It should be noted that there has always been a trickle of mentally retarded people discharged from the large institutions to the community. In some cases institution superintendents would release people who were clearly not retarded or whose parents or relatives demanded their release. By the 1920's, especially in the northeastern United States, there were a myriad of parole or community release programs attempted. In Ontario, as noted above in Chapter 5, B.T. McGhie inaugurated a parole program. On the period from 1961 to 1974 in southwestern Ontario see Reginald M. de Silva and Patricia Faflak, "From Institution to Community — A New Process?" *Mental Retardation,* Volume 14 (December, 1976) pp. 25-28.

15 See Sharen Hudson and Mora Skelton, *Some Positive Advances in Conditions for Retarded Persons in Ontario: 1970–1976,* OAMR Staff Working Paper, 1976, p. 4.

16 The smokescreen of rhetoric that surrounded the program is illustrated by a statement from G.C. Cormack and S.A. Holling, both of whom were involved in the program. "It was important that the hospital staff realize that the program was . . . oriented towards placing patients back into the community. The mental hospital stay could be seen as a chronic dehumanizing process since these hospitals tend to be overcrowded and understaffed. Through co-operation in such a program the patients could be placed in suitable homes." See G.C. Cormack and S.A. Holling, "Homes for Special Care Program, Province of Ontario," *Canadian Journal of Public Health,* Volume 56 (November, 1965), p. 472. In light of overwhelming evidence that the program was a failure from the beginning, that it was motivated primarily by a desire to save money, and that the vast majority of residents continued to live in dehumanizing conditions, statements of this kind would be laughable if the matter were not so tragic. What is even more puzzling is that as recently as March 1981, two observers wrote that: "Several studies . . . have shown that the early goals of the program were readily achieved." Yet these same authors note that in 1981 there were "21 field workers responsible for 4,002 nursing home residents and 1,681 residential home residents in 549 homes." Twenty-one field workers for a total of 5,683 people! See G.M. Tekatch and S. Sussman, "Current Status of Homes for Special Care," *Canada's Mental Health,* Volume 29 (March, 1981), p. 34.

17 Cormack and Holling, p. 472.

18 See C.A. Roberts, p. CR-79.

19 Cormack and Holling, p. 470.

20 Ontario, Department of Health, *44th Annual Report,* 1968, p. 54.

21 *Debates,* Supply Committee, October 19, 1970.

22 *Ibid.*

23 F.A. Allodi and H.B. Kedward, "The Vanishing Chronic," *Canadian Journal of Public Health,* Volume 64 (May-June, 1973), pp. 281-286.

24 J.A. Sylph, M.R. Eastwood, and H.B. Kedward, "Long Term Psychiatric Care in Ontario: The Homes for Special Care Programme," *Canadian Medical Association Journal,* Volume 114 (February 7, 1976), p. 233.

25 R.M. Titmuss, *Commitment to Welfare* (London, 1968), p. 22.

26 Simmel, pp. 52 ff.

27 The long-time director of Ontario's large mental retardation facilities, Dr. Ron Farmer, admitted this in the Legislature. "Certainly, I agree that there are sins of the past and there are some stories around about individuals who were not retarded but who were in our facilities because of some other type of handicap. I think that some of these probably had been admitted in years gone by because of very disturbed behaviour and the fact that there was no other place to care for them in the community. . . . I think that picture has now changed." *Debates,* Supply Committee, November 7, 1979.

28. Letter from Premier Robarts to Mrs. Russell in personal files made available to author by Mrs. Elva Telfer.

Chapter 10

1 Walter Williston, *Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario,* Department of Health, 1971.

2 *Ibid.*, p. 65, ff.

3 *Ibid.*, p. 73.

4 *Ibid.*, pp. 91-92.

5 This was confirmed by a number of people in interviews.

6 Mr. Williston expressed these views to me in an interview conducted shortly before his death.

7 N.E. Bank-Mikkelsen quoted in Wolf Wolfensberger, *The Principle of Normalization in Human Services* (Toronto, 1972), p. 27.

8 *Ibid.*, p. 27.

9 *Ibid.*, p. 28.

10 Interview with Dr. G. Allan Roeher.

11 *Debates,* December 15, 1971.

12 On the history of mental retardation policy from the 1960's to 1973, see *Community Living for the Mentally Retarded in Ontario: A New Policy Focus,* (hereafter referred to as the Green Paper), Provincial Secretariat for Social Development, March, 1973, p. 5.

13 *Debates,* April 25, 1972.

14 *Ibid.*

15 *Debates,* May 23, 1972.

16 Interview.

17 Anglin and Braaten, p. 65, also interview.

18 Committee on Government Productivity, *Management of Government: A Re-Appraisal* (Queen's Park, 1971).

19 R.K. Foot, *op cit.*, p. 14.

20 COGP, *Interim Report No. Three*, p. 3.

21 *Ibid.*, p. 17.

22 *Ibid.*, p. 25.

23 On the effect of the COGP report on government see George J. Szablowski, "Policy-Making and Cabinet: Recent Organizational Engineering at Queen's Park," in Donald C. MacDonald, editor, *Government and Politics of Ontario* (Toronto, 1975), pp. 114-134. On the failed mission of policy secretariats, see especially pp. 124-126.

24 *Green Paper*, p. 4.

25 *Ibid.*, pp. 17-18.

26 *Ibid.*, p. 19.

27 *Ibid.*, p. 21.

28 *Ibid.*, p. 22.

29 *Community Services for the Mentally Retarded: Detailed Program Proposal and Implementation Plan*, Ministry of Community and Social Services, April 17, 1975, p. 3.

30 Anglin and Braaten, p. 66.

31 The author conducted interviews with a number of the participants, both politicians and bureaucrats, who were associated with the switch.

32 On the Canada Assistance Plan see Andrew Armitage, *Social Welfare in Canada* (Toronto, 1975), pp. 133-135.

33 There is one crucial difference between the American and Canadian programs as first established. In Canada, CAP funds were quickly put to use by provincial governments to support provincial mental retardation facilities. In the U.S., with certain exceptions, federal funds could not be used to support state institutions. Thus, there was an incentive for the states to use the funds to subsidize private institutions for facilities for mentally ill mentally retarded people. See Gary J. Clarke, "In Defense of Deinstitutionalization," *Milbank Memorial Fund Quarterly*, Volume 57 (1979), p. 469.

34 COMSOC, *Transfer of Mental Retardation Services: Proposals for a Transfer Timetable*, Hickling-Johnston, August, 1973.

35 The task force consisted of David MacCoy from COMSOC, Hal Jackman, Senior Policy Advisor to Robert Welch, and Donald Zarfas from the Ministry of Health. See COMSOC, *Transfer of Mental Retardation Service: Report of the Program and Operations Task Force*, November 23, 1973.

36 *Ibid.*, pp. 21-22.

37 There were some exceptions. One egregious example was mentioned in the *Globe and Mail* on November 11, 1975. A pensioner who was handling a $12,000 estate for his brother, a resident at Pine Ridge Centre in Aurora, was billed $12,256 by the government. It was explained that once the full estate was turned over to the government, less the $1,500 allowed to the resident under the Family Benefits Act, then Family Benefits would be sufficient to pay for upkeep.

38 *Transfer of Mental Retardation Service: Report of the Program and Operations Task Force*, p. 23.

39 Hickling-Johnston, p.46.

40 *Task Force*, p. 7.

41 *Debates*, October 4, 1973.

42 Although there is some disagreement in Ontario as to whether the switch of mental retardation services from Health to COMSOC came about because of the availability of CAP funds or because of other reasons, no such ambiguity surrounds a similar decision taken in 1977 in Nova Scotia. On March 28, 1977, the Minister of Finance of Nova Scotia said that mentally retarded people had been transferred out of the Department of Public Health "for the purpose of obtaining federal cost-sharing in respect of those qualifying." Quoted in Cameron McQueen, *Nova Scotia Policy, 1965-1977 for Moderately and Severely Mentally Handicapped Adults*, School of Public Administration, Faculty of Administrative Studies, Dalhousie University, 1977.

43 COMSOC, *Discussion Paper on a New Mental Retardation Program for Ontario*, May, 1974, p. 4. Hereafter referred to as *Avocado Paper*.

44 *Globe and Mail*, March 10, 1977. In this context it is interesting that in the 1971 British White Paper *Better Services for the Mentally Handicapped* it was estimated that between one third and one half of people in hospital could be discharged "if residential and other facilities were available in the community." Cmnd. 4683, June 1971, p. 48.

45 *Avocado Paper*, p. 7.

46 *Ibid.*, p. 3.

47 *Ibid.*, p. 6.

48 The speech was actually written by Alan Gordon, and it merely formalized a previous commitment made by COMSOC Minister René Brunelle who stated that CAP funds would be "reinvested in facilities for the retarded." *Debates*, March 26, 1979. There is, of course, no way to determine whether these funds were used for mental retardation policy since one does not know how much the province would have spent in their absence. According to my calculations, however, (see Appendix A) the province seems to have used the federal funds to subsidize the existing level of expenditure on mental retardation policy. That is, the injection of federal funds did not lead to a marked increase in provincial spending in this area. Moreover, despite the appallingly low level of care given to mentally retarded people in the Homes for Special Care program, there is no evidence that CAP funds were used in any way to help mentally retarded people in that program.

for Special Care program, there is no evidence that CAP funds were used in any way to help mentally retarded people in that program.

49 COMSOC, *Discussion Paper on Planning and Organizing for Services to the Retarded in Ontario,* September, 1974, p. 4.

50 See Walter Jaehnig, *A Family Service for the Mentally Handicapped,* Fabian Tract 460 (London, 1979).

51 Interview with A. Gordon. Apparently few people in the OAMR considered this alternative either for, as the authors of the 1976 *Role Study* pointed out: "The possibility of Municipal or Regional Government acting as agents of service delivery to the retarded is seldom considered." OAMR, *Position Paper on the Future Role of the OAMR* (September, 1976), p. 9.

52 Interview with A. Gordon.

53 Interview with M. Scott.

54 OAMR, *Response of the OAMR to the Report of the Task Force on Community and Social Services,* September 14, 1973.

55 The author conducted extensive interviews with most of the civil servants who played an important role in mental retardation policy in COMSOC from 1974 to 1977.

Chapter 11

1 On policy termination see Eugene Bardach, "Policy Termination as a Political Process," *Policy Sciences,* Volume 7 (1976), pp. 123-131.

2 Dr. Donald E. Zarfas, "Moving Toward the Normalcy Principle in a Large Government Operated Facility for the Mentally Retarded," *op. cit.*

3 Bardach, p. 120.

4 There was a general consensus among civil servants interviewed that personality problems bulked large in the Ministry immediately after the 1974 switch.

5 See "Writ of Summons, Supreme Court of Ontario," No. 11901, March 31, 1977 between Ralph William Blakeman and Joseph W. Willard, p. 13.

6 Kathleen Rex, "Province Wants 700 Retarded Moved out of Institutions," *Globe and Mail,* January 10, 1975.

7 See Joseph Willard, *Inquiry into the Management and Operation of the Huronia Regional Centre, Orillia* COMSOC, November 18, 1976. Willard says: "It is apparent that, currently, the depopulation of Huronia Centre is being achieved mainly by providing room for residents in other smaller centres."

8 *Debates,* Supply Committee, May 15, 1975. MPP Harry Parrott stated that people were transferred from the Oxford Regional Centre at Woodstock to nursing homes.

9 *Ibid.*

10 See for example, the *Globe and Mail,* March 22, 1974 which quoted the chairman of the Ontario Hospital Schools Committee of the Metro Toronto Association for the Mentally Retarded as saying: "There is always going to be a need for Orillia. We want them to start building this complex [a proposed $4 million addition to the buildings at Orillia] right away."

11 Letter from James Taylor, Minister of Community and Social Services to Mr. G. Murless, President of the Mississauga Association for the Mentally Retarded, February 13, 1976.

12 Interview with D. MacCoy.

13 Willard, p. 210.

14 *Ibid.*, pp. 201 ff.

15 Dr. Benjamin Goldberg, "Comprehensive Community Programming Revisited," speech to the Twenty-Second Annual Meeting of the OAMR, London, Ontario, May 12, 1975. Dr. Goldberg later took over briefly as the Administrator of Orillia after R.W. Blakeman was fired by the government in November, 1976.

16 *Debates,* Social Development Committee, June 21, 1978.

17 *Globe and Mail,* February 28, 1978.

18 Ontario Public Service Employee's Union, *Ontario's Mental Health Breakdown* (August, 1980), p. 62.

19 COMSOC, *Mental Retardation Policy in Ontario,* a joint paper from Program Policy, Children's Services Division and Program Policy, Adult Division, 1979, p. 14.

20 There are still mixed opinions about the degree of improvement that has taken place in the large institutions. For example, on February 14, 1980, the chairperson of the OAMR Residential Services Committee reported on a visit to the Oxford Regional Centre in Woodstock: "I had the great displeasure of seeing this facility on February 10, 1980. The Ministry of Community and Social Services can be congratulated for creating another snakepit." OAMR files.

21 Interview.

22 *Debates,* Supply Committee, June 13, 1974.

23 *Ibid.*, June 18, 1974.

24 For a critical view of this assumption see Ralph M. Kramer, "Voluntary Agencies in the Welfare State: An Analysis of the Vanguard Role," in *Journal of Social Policy,* Volume 8 (1974), pp. 473-488.

25 Robert Pinker, *The Idea of Welfare* (London, 1979), p. 6.

26 *Debates,* Social Development Committee, October 24, 1977.

27 *Ibid.*

28 *Ibid.*, October 24, 1977.

29 A recent study in Ontario of the possible effects on health care of the relationship between user fees and greater efficiency says: "The stated purpose of this paper was to explore, under quite general assumptions, whether direct charges to patients offered significant tangible social benefits. Unfortunately for public policy (because such charges are often relatively easily implemented) the answer seems to be no. In fact, most such policies appear likely to produce positive social harm. It has been shown that the necessary preconditions for the success of direct charges in achieving a plausible range of policy objectives are rarely satisfied and, that when they are, other operational impediments may preclude policy success." See M.L. Barer, R.G. Evans and G.L. Stoddart, *Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion?,* Ontario Economic Council, Occasional Paper 10 (Toronto, 1979). Of course, analogies are not identities, and it may well be that user charges in the area of mental retardation policy do lead to "tangible social benefits."

30 *Debates,* Supply Committee, November 7, 1979.

31 *Community Services for the Mentally Retarded: Detailed Program Proposal and Implementation Plan,* p. 16.

32 Edward Magder in COMSOC, "A Review of Residential Care Facilities for Children and Youth in Ontario," *Interministry Report on Residential Services,* April 14, 1975, p. 89. The *Interministry Report* is one of the most detailed and certainly one of the most fascinating of government documents on the various residential services provided by the Ontario government. The authors provide an enormous wealth of data on the financing and administration of these services, and raise serious questions about the extraordinary variations in charging practices as between these services.

33 See Lillian Keys, *Developmentally Handicapped Children and Adolescents Currently in the Care of the Children's Aid Society of Metropolitan Toronto and Related Issues,* Children's Aid Society, February 1977, p. 5.

34 COMSOC, *Community Services for the Mentally Retarded: Detailed Program Proposal and Implementation Plan,* p. 90.

35 *Debates,* June 21, 1976.

36 *Ibid.,* October 24, 1977.

37 COMSOC, Memorandum from Alan Gordon to Facility Administrators, etc., January 30, 1978.

38 Personal communication from F.W. Males, Coordinator of Homes for Special Care Program, Ministry of Health, to author, September 4, 1980.

39 See statement of D. Crittendon that the deadline for the transfer was October 1, 1975 in *Debates,* Supply Committee May 15, 1975.

40 Ministry of Health, *It's a Matter of Caring,* pamphlet, December, 1974, p. 6.

41 Rosemary Boyle, "From Dreary Wards to Life's Backwaters," in *Globe and Mail,* February 12, 1976.

42 Ministry of Health, *Homes for Special Care: Task Force Report,* August 26, 1976, p. 2.

43 *Ibid.*, p. 3.

44 *Globe and Mail*, February 13, 1976.

45 Dorothy Upton, *et. al., Concerns and Recommendations Regarding the Good Samaritan Nursing Home, Alliston, Ontario,* OAMR, September, 28, 1979.

46 Richard J. Miles, *Proposals and Strategies for Homes for Special Care*, OAMR, August 13, 1979.

47 Letter to Dennis Timbrell, Minister of Health from OAMR Executive Committee member Ivy Ellingham, December 12, 1979 and letter to OAMR Executive Committee from Roy Beechy, December 24, 1979. From the tone of the correspondence and internal memoranda, it is quite clear that the OAMR executive was fed up with government inaction.

48 In a speech at Sir Wilfred Laurier University on October 20, 1979, Professor Greenland spoke about the presence of mentally retarded children in the Homes for Special Care. This was reported in the *Hamilton Spectator* for that date. On Professor Greenland's discovery of deaf-blind children in institutions for the mentally retarded see Michele Landsberg's column in the Toronto *Star*, October 22, 1979. Also see the *Globe and Mail*, March 17, 1980 summarizing Professor Greenland's and the OAMR's fight to improve services in the Homes for Special Care and to transfer children out of the program altogether.

49 COMSOC, *Mentally Retarded Clients in the Homes for Special Care and Extended Care Program: Information Paper,* April, 1980.

50 Figures quoted in Stanley R. Kurisko, *A Proposal for Review of the Homes for Special Care Program,* OAMR, December 9, 1975.

51 *Debates,* Supply Committee, June 11, 1974.

52 Minutes of the OAMR Annual Meeting, April 22, 1976.

53 *Globe and Mail*, March 10, 1977.

54 Letter from Stanley R. Kurisko, President of the OAMR to Keith Norton, Minister of Community and Social Services, February 28, 1977.

55 This is a summary of Rosemary Dybwad's position as sketched in the *Role Study,* Pt. 3, p. 2.

56 *Ibid.*, Pt. 3, pp. 6-7. The same kind of argument about a trend away from private, voluntary, local and specialized services toward public, legislated, national and comprehensive services had been made in relation to mental health by Dr. William Ryan in 1969. Given the recent attempt in many industrialized countries to make local communities, voluntary organizations and families responsible for sharing the financing and administration of the social services, it is obvious one should be careful about extrapolating social trends too far into the future. See William Ryan, "Community Care in Historical Perspective," *Canada's Mental Health,* Supplement No. 60 (March-

April, 1969).

57 *Role Study,* Pt. 1, Appendix I.

58 Richard J. Miles, *op. cit.*

59 *Ibid.*, pp. 10-11.

60 See Carolyn J. Tuohy, "Pluralism and Corporatism in Ontario Medical Politics," in K.J. Rea and J.T. McLeod, *Business and Government in Canada* (Agincourt, 1976), p. 398.

61 In his interesting study of the Addiction Research Foundation in Ontario, Professor David V.J. Bell has come to pretty much the same conclusions. He notes that frequent shifts in ministers have "made it difficult for the ARF to establish effective working relationships with the relevant ministers and senior officials. By the time they have been educated to the ARF point of view they get transferred. ARF must accordingly put greater emphasis on relations with senior and middle level bureaucrats who tend to stay in the same ministry much longer than ministers themselves." David V.J. Bell, *Political Factors Affecting the Mission of the Addiction Research Foundation,* MS, March, 1980, p. 58. Bell's assumption that civil servants serve longer in one post than their Minister may not always be true for all Ministries. In COMSOC while there were three separate Ministers from 1974 to 1980 the Deputy Minister changed twice, (actually three times, for Dr. Ron Farmer held the post of Deputy Minister for a few days just prior to the appointment of Ms. Crittenden), while middle level bureaucrats were constantly being reshuffled. It is possible to break linkages between the bureaucracy and interest groups and to diffuse responsibility by intradepartmental reorganizations as well as by transferring personnel from one department to another. Thus, the personnel within a department or ministry may remain the same, but because their tasks change the same effect is achieved.

62 Interview.

63 Ontario Welfare Council and the Social Planning Council of Metropolitan Toronto, *And the Poor Get Poorer: A Study of Social Welfare Programs in Ontario,* February, 1981, pp. 74 and 76-77.

64 Certainly there is evidence that the enormous postwar increase in provincial expenditures on the various social services was prompted by the federal government. Vernon Lang has written: "Federal legislative and fiscal pressures, mostly in place by 1966 exerted tremendous leverage on Ontario's social polices from 1967 on." See Vernon Lang, *The Service State Emerges in Ontario: 1945–1973* (Toronto, 1974), p. 39. In an excellent econometric analysis of public expenditure in Ontario, D.K. Foot has also noted: "The availability of federal funds has clearly been an important determinant of hospital, education and some social welfare expenditures and, since these are very large categories, much of the growth since the mid-sixties (in addition to the basic demand determinants) can be traced to this source. Generally, it appears as though these have been a substitute for provincial expenditures." See D.K. Foot, *op. cit.*, p. 190.

Chapter 12

1 See the *Globe and Mail* series on nursing homes, "Who Care for the Aged?" March 14-18, 1981.

2 Asa Briggs, "The Welfare State in Historical Perspective," in *Archives Européens de Sociologie,* Volume 2 (1961), p. 228. Interestingly enough the only comprehensive analysis published of the development of social policy in Ontario since 1945 refers not to a welfare state but to a "social service state." See Vernon Lang, *The Service State Emerges in Ontario: 1945-1973* (Toronto, January 1974). Lang uses the term "social service state" as his heading for Chapter 1.

3 Quoted in Karl de Schweinitz, *England's Road to Social Security,* (New York, 1972), p. 20.

4 See Elizabeth Wallace, "The Origins of the Social Welfare State in Canada: 1867–1900," in *Canadian Journal of Economics and Political Science,* Volume 16 (August, 1950), pp. 383-393.

5 T.H. Marshall, *Social Policy* (London, 1970), p. 76.

6 See, for example, Karl Polanyi, *The Great Transformation* (Boston, 1968); E.H. Carr, *The New Society* (Boston, 1957); and H.L Beales, *The Making of Social Policy* (London, 1946).

7 See, for example, Friedrich A. Hayek, *The Road to Serfdom* (London, 1962), and Ludwig Von Mises, *Theory of History* (New Haven, 1957.)

8 See John Saville, "The Welfare State: An Historical Approach," in *New Reasoner,* Volume 3 (Winter, 1957/58), "In the last resort, the determining factors in the evolution of the Welfare State will be the degree of organization, and the determination to insist upon change on the part of the working people themselves," p. 9.

9 Joseph Chamberlain quoted by Saville, in *Ibid.*, p. 14.

10 For example, in a recent interview of Ferdinand Lundberg, *Cracks in the Constitution,* Gore Vidal quotes Lundberg as saying that twenty-five percent of the American population is comprised of "the superannuated, the unskilled, the immature of all ages, the illiterate, the improvident propagators, the mentally below par or disordered." See Gore Vidal, "The Second American Revolution," in *The New York Review of Books,* Volume 28 (February 5, 1981), p. 41.

11 This is not to say there are no conflicts between those who man the welfare state system and government. In Canada there is currently a good deal of friction between the Federal Liberal government on one side, and the medical profession and most of the provinces on the other over whether or not doctors should be allowed to extra-bill patients. In Ontario, however, the Progressive Conservative government has traditionally been extremely deferential to the medical profession, and despite occasional clashes has been highly protective of the doctor's professional independence and financial position. In the case of Ontario, Donald Swartz is probably not exaggerating when he claims: "In short, state hospital and medical insurance effected no change in the nature of the health care system. Its control remained firmly

in private hands, held by physicians and the drug and medical supply corporation. What health insurance amounted to was an unlimited subsidy to these fractions of the bourgeoisie in the form of a guarantee by the state of payment for any services and goods physicians mandated." See Donald Swartz, "The Politics of Reform: Conflict and Accommodation in Canadian Health Policy," L. Panitch, editor, *The Canadian State: Political Power* (Toronto, 1977), p. 330.

Appendix A

In the accompanying tables I have attempted to show what the relative weight of expenditures on institutions for the mentally ill and mentally retarded people was in comparison to total government expenditures from 1878 on. In calculating the total for mental retardation expenditures I have included all monies spent for both capital and maintenance.

Since, for a long time, Orillia was the only institution specifically intended for mentally retarded people, I have assumed that expenditures on Orillia represent total government expenses for mental retardation policy from 1876 to 1931/32. After that date I include expenditures on Cobourg, which was gradually filling up with mentally retarded women, and then expenditures on the additional institutions constructed during the post war period, e.g. Aurora, Smiths Falls, Cedar Springs, Children's Psychiatric Research Institute, Palmerston, Edgar, Mental Retardation Centre, Toronto (Surrey Place), etc. The source for the data is the Ontario Public Accounts which provides figures for both capital and operating expenses. Unfortunately specific figures for individual institutions were provided in the Public Accounts only until 1968/69, after that date only total expenditures for all institutions are available.

As regards the calculation of annual total government expenditure, this was difficult to do, and in the end meant selecting from among an array of possible figures. From 1876 to 1923/24 I have used the figure under the heading "Total Expenditure under Supply Bill." These were expenditures which the legislature had to vote on annually, as contrasted with certain required or "statutory" expenditures which the legislature was required to make as a result of past commitments. At the end of the nineteenth century, for example, such required expenditures were listed

under the "railway subsidy fund," "annuities," or "drainage debentures." The reason for excluding statutory expenditures from my calculations of total government expenditure is that as the government grew and began to borrow, and as it assumed long term commitments such as servicing the public debt, the amount expended each year was partly determined by the obligations undertaken in previous years. For example, since the interest on a loan must be paid at a fixed rate every year, the legislature does not have to debate the question of appropriating funds to service the debt. Thus there were many areas where the original statute committed the government to fixed expenditures. As best as possible, therefore, I have calculated how much the government spent each year of those sums appropriated for various government activities that were not based on long term or fixed commitments. It seemed to me that if legislators were interested in the question of economizing in one or another area, they would look to those policy areas where they had some flexibility, and not to expenditures that were required as "statutory expenditures."

One difficulty is that until 1946 there was no reliable transcript of legislative debates. Moreover, a search of the available records before that date failed to turn up any evidence of discussions in the legislature about expenditures on mental retardation policy. This does not mean that no discussions took place, but that if they did, they were not reported. Thus the expenditure figures are an indirect indication of the relative importance of mental retardation policy in Ontario. If there were discussions about expenditures on mental retardation policy most likely they would have taken place in the office of the Provincial Secretary until 1930, and then, with the transfer of the hospitals, in the Department of Health after that date. Of course, there may also have been discussions in the Cabinet or in the office of the Premier, but except for occasional evidence as in the case of Premier Hearst's objections to the idea of building additional institutions in 1917, there is no available evidence of such discussions.

From 1924/25 to 1935/36 I have calculated total government expenditure by adding ordinary and capital expenditures as listed in the Public Accounts for those years but excluding all sums under public debt, statutory expenditures or special warrants. I have included spending on hydro-electric power. Thus, the totals for this decade cover approximately the same categories and are comparable to the totals for the previous years.

After 1936/37 the Public Accounts provide two statements of expenditure each broken down into sub-categories. One is a statement of ordinary expenditures (which provides figures for gross expenditures, reimbursements and net expenditures); a second statement adds net expenditures and capital disbursements to arrive at "net disbursements." From 1936/37 to 1963/64 I use the total under net disbursements, that is net ordinary expenditure excluding reimbursements plus capital disbursements as the total for government expenditure. I have excluded all figures listed under public debt, unemployment relief, etc. from this

total. Here too I wished to arrive at a figure which indicated how much the provincial government was spending each year as result of policy decisions likely to have been discussed or debated in the legislature or in public.

From 1964/65, however, the basis for calculating total government expenditure changes. In 1973 the provincial government began to provide figures for "total budgetary expenditures." This figure includes the public debt, plus federal government reimbursements plus additional expenditures. The 1973 Ontario Budget statement recalculated total budgetary expenditures under this new system back to 1964/65. For the sake of consistency, therefore, I have used these recalculated figures from 1964/65 as the basis for total government expenditure, and I have calculated the weight of mental retardation policy as a percentage of this figure.

Keeping in mind that the figures are only approximations, and that the figures after 1964/65 are not comparable to those prior to that date, a look at the expenditure trends for mental hospitals and mental retardation institutions in Ontario over the past century seems to indicate the following.

By the end of the nineteenth century, an enormous proportion of public expenditures in Ontario were devoted to asylums of all kinds. As a percentage of all public spending, asylum expenditures in 1878 reached nearly 19 percent, while by 1890 they reached the extraordinary figure of 24.3 percent. In that same year, 4.4 percent of all provincial expenditures went to maintenance and capital costs at Orillia. Never before, and never again would such a large proportion of government expenditure be devoted to mentally ill and mentally retarded people. During the final years of the nineteenth century there was a wave of asylum building throughout North America as asylum and government authorities desperately sought to keep up with the demand for space. At this time social welfare and social service expenditures constituted only a small proportion of public expenditures, so that the proportion of expenditures devoted to asylums bulked large in government budgets. Later, as governments gradually began to build the foundations of the social service state, and to devote increasing expenditures to the infrastructure of industrial capitalism, asylum expenditures began to shrink as a proportion of total government expenses. By 1900, for example, asylum expenditures comprised a little more than 18 percent of provincial expenditures, and by 1910, only 11 percent.

The year 1890 also marked the high point for Orillia as regards expenditure. In that year the main building and two large three-story cottages were completed, but the institution soon began to overflow with residents. Most of the expenditure at that time was devoted to buildings rather than to maintenance for the patients. By 1896 A.H. Beaton complained: "The cost for maintenance has reached the low mark of $98 per capita per annum. This is undoubtedly the lowest rate of any institution

of like pretensions in the world to-day and it is a question if it is too low . . . when compared with like institutions, we wonder where the economy comes in."[1] Expenditures on Orillia continued to fall until 1918 when for a brief moment they increased as the government again embarked upon a building program. But they fell precipitately during the interwar period and only rose again three decades later as the government again responded to the pressure for increased accommodation by opening a new institution at Aurora and constructing the massive Smiths Falls facility in 1951/52. By the 1960's expenditures began to fall once again as Dr. Dymond and his successors decided to abandon the century old tradition of basing mental retardation policy on large institutions. After 1970/71 expenditures rose as mental retardation policy emerged as an issue of great importance. Under external pressure from OAMR, the press and the opposition, and because of internal pressure from civil servants, the government began to move in the direction of expanded community programs and services. In addition, major changes occurred as regards the distribution of expenditures within mental retardation policy. Expenditures on community programs (community residences, sheltered workshops, day nurseries, protective service workers) rose as a percentage of mental retardation expenditures while expenditures on the Schedule I institutions steadily declined after 1965/66. Whereas only 4.2 percent of mental retardation expenditures went to community programming in 1965/66, by 1980/81 35.4 percent of expenditures were in the field of community programming.

In this sense, the government seems to have stuck to the policy enunciated in the 1970's of re-orienting mental retardation policy away from emphasis on large institutions and toward increased community programs. However, serious questions can be raised about whether the provincial government has increased the relative amount it has spent on mental retardation policy, or whether the increase in spending was mainly due to transfer payments from the federal government. As can be seen from Table 2 the weight of mental retardation expenditures as a percentage of provincial government spending declined from 1965/66 to 1969/70 after which point there was a sharp and nearly continuous rise in spending. However, when one subtracts the transfer payments from the federal government which came through the Canada Assistance Plan or through Established Program Financing grants, then the picture looks quite different. Because transfer payments to the province did not come in equal sums over the years, I have taken the total amount transferred from 1973/74 to 1980/81, $437,109,000 and averaged it over eight years to give a figure of $54,638,635 that I have then subtracted from annual provincial mental retardation expenditures for the period from 1973/74 to 1980/81. What this indicates is that only by 1976/77 did the province spend a bit more of exclusively provincial funds than it did in 1969/70 (.99 percent in 1976/77 as compared with .93 percent in 1969/70.) Moreover, by 1980/81, the high point of provincial expenditure, the pro-

vince was spending exactly the same proportion of exclusively provincial funds on mental retardation as it did in 1971/72, two years before the massive injection of federal funds began to boost total provincial expenditures on mental retardation policy.

What does this mean? In his Peterborough speech of May 16, 1974, Premier Davis promised the OAMR that funds received from Ottawa would be devoted to programs for mentally retarded people. Later in his speech he said these funds would be used for new programs for retarded people. Evidently many of those involved in the OAMR interpreted Davis to mean that federal funds would be devoted to community programming. However, there is nothing in Davis's speech that can be interpreted in this way. What is at issue, however, is the difficult question of whether the government actually used federal transfer payments to subsidize provincial expenditures on mental retardation policy. In one sense this question is unanswerable, for one simply does not know how much the provincial government would have spent of exclusively provincial funds on mental retardation if no federal aid had been available.[2] However, once one subtracts federal transfer payments from provincial expenditures, it reduces the total substantially. Given the fact that during the 1970's provincial expenditures on mental retardation policy were rising quickly; that the government had committed itself to a major re-orientation in policy toward community programming and that the Premier himself had implied increasing expenditures on mental retardation policy, it is quite clear that the province had already committed itself to a continuing high level of expenditure on mental retardation policy. However, the massive injection of federal funds was used to subsidize those expenses.

By 1980, therefore, the major re-orientation of mental retardation policy had occurred in the area of policy rather than in any radical increase in government funding. For example, there has been a continued increase in the percentage of funds devoted to community programs, and a continued decline in the percentage of funds devoted to large institutions. Morever, there has been a continued rise in the number of mentally retarded people living in the community and deriving their income from social welfare funding. Since these people no longer make use of facilities or services funded under mental retardation policy there is no way to calculate how much the province spends on these people as differentiated from other welfare recipients.

Nevertheless the fate of mentally retarded people is influenced both by the existing level and quality of facilities and services specifically provided for mentally retarded people, as well as by the level and quality of social welfare expenditures. Current indications are that provincial expenditures in both areas will decline over the next few years, and that as a result, future programs may never come to fruition, while existing programs may have to be cut back. This raises the further question of whether the result of cutbacks will be to slow down even further the process of deinstitutionalization and community integration, with a con-

sequent slow growth in the size of the large Schedule I institutions.

Notes

[1] OSP, 1897, Volume 29, Pt.4, No. 10, p.258

[2] In a study of public finance in Ontario, D.K. Foot states that federal funds have "been a substitute for provincial expenditures". See D.K. Foot, *Provincial Public Finance in Ontario: An Empirical Analysis of the Last Twenty-Five Years* (Toronto, 1977), p.190.

Table 3 Percentage of Government Expenditures Comprised by Expenditures on Mental Retardation Institutions and on Provincial Asylums from 1876–1981.

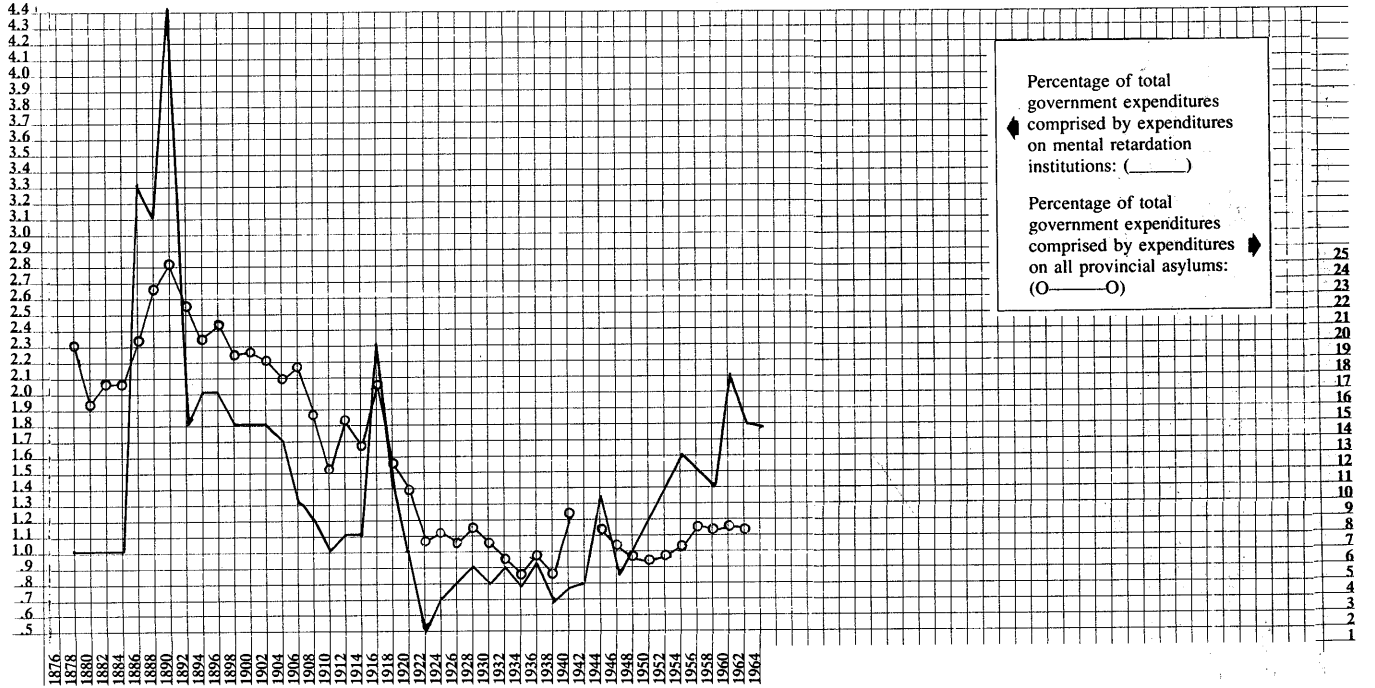


Table 3 (continued)

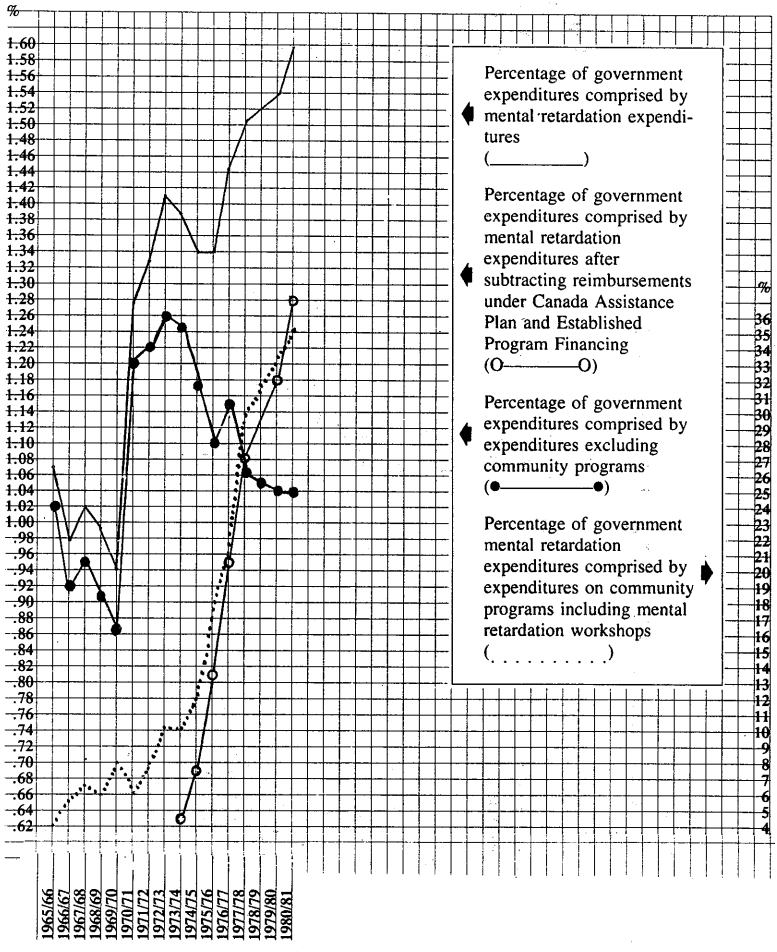


Table 4 Total Government Expenditures and Expenditures on Mental Retardation Policy: 1876–1981

Year	Total Government Expenditures	Government Expenditures on Mental Retardation (Capital + Operating)		Expenditures on Mental Retardation as % of Total Government Expenditures
1876		41,838		
1878	2,408,537	24,804		1.03
1880	2,243,665	22,152		.98
1882	2,425,896	26,375		1.08
1884	2,870,035	29,845		1.04
1886	2,769,978	93,102	*New buildings*	3.36
1888	3,007,037	94,871	*under construction at*	3.15
1890	3,367,685	148,661	*Orillia*	4.41
1892	3,411,012	61,207		1.79
1894	3,374,379	66,650		1.97
1896	3,415,274	69,444		2.03
1898	3,567,128	65,563		1.83
1900	3,748,159	67,271		1.79

Table 4 (continued)

Year	Total Government Expenditures	Government Expenditures on Mental Retardation (Capital + Operating)		Expenditures on Mental Retardation as % of Total Government Expenditures
1902	4,064,663	72,146		1.77
1904	4,953,309	84,137		1.69
1906	5,881,800	79,401		1.34
1908	7,298,517	86,148		1.18
1910	9,929,917	90,443		.91
1912	10,167,562	117,162		1.15
1914	14,803,327	173,910	*New buildings under*	1.17
1916	11,432,259	262,587	*construction at*	2.29
1918	18,043,583	246,976	*Orillia*	1.36
1920	32,107,035	317,091		.98
1922	44,231,705	224,033		.5
1924	45,018,315	298,836		.6
1926	48,018,533	406,958		.84
1928	57,679,900	506,832		.87
1930	71,031,844	555,337		.78
1932	68,987,740	683,415		.99
1934	89,419,782	651,067		.72
1936	52,755,002	502,369		.95
1938	90,796,067	642,477		.70
1940	88,079,031	691,626		.78

Table 4 (continued)

Year	Total Government Expenditures	Government Expenditures on Mental Retardation (Capital / Operating)		Expenditures on Mental Retardation as % of Total Government Expenditures
1942	89,610,041	734,066		.81
1944	80,673,056	1,096,955		1.35
1946	105,478,471	980,168		.92
1948	213,570,763	2,373,669	*Smiths Falls under*	1.11
1950	235,398,378	3,266,582	*construction*	1.38
1952	317,314,610	4,732,237		1.49
1954	378,426,197	5,946,644		1.57
1956	449,602,786	6,854,192		1.52
1958	624,370,042	8,698,786	*Cedar Springs and*	1.39
1960	749,131,740	15,870,830	*Children's Psychiatric*	2.11
1962	889,996,904	16,154,345	*Research Institute open*	1.81
1964	1,078,506,300	19,189,541	*Aurora and Palmerston open*	1.78
1966	1,958,700,000	20,994,000	*Edgar opens*	1.07
1968	3,003,900,000	30,607,450	*Surrey Place opens*	1.02
1970	4,251,000,000	39,956,700		.93
1971	5,216,700,000	66,707,800		1.27
1972	6,028,000,000	80,311,600		1.33
1973	6,412,000,000	90,240,100		1.40

Table 4 (continued)

Year	Total Government Expenditures	Government Expenditures on Mental Retardation (Capital / Operating)	Expenditures on Mental Retardation as % of Total	
			Government Expenditures	After subtracting federal contributions calculated on an annualized basis
1974	7,223,000,000	100,567,200	1.39	.63
1975	8,722,000,000	116,835,000	1.33	.71
1976	10,490,000,000	140,588,660	1.34	.82
1977	11,743,000,000	171,693,000	1.46	.99
1978	12,920,000,000	195,466,200	1.51	1.09
1979	13,913,000,000	213,376,304	1.53	1.14
1980	15,368,000,000	238,323,200	1.55	1.19
1981	16,836,000,000	270,290,900	1.60	1.28

Appendix B

This section contains statistics on the numbers, and various characteristics of mentally retarded people in provincial institutions from 1872 on. Prior to that date there were mentally retarded people in the various provincial asylums, but they were listed under the category of "lunatic" since the statutes did not yet provide for the commitment of those whose primary diagnosis was "idiotic."

Mentally retarded people were housed in the Idiot Asylum at the London Lunatic Asylum from 1872 to 1875, and then transferred to the Orillia Asylum in 1876. From 1879 to 1881 a ward for mentally retarded people was opened at the Hamilton Lunatic Asylum, but the residents were then transferred to Orillia in 1881. With these exceptions the figures from 1879 to 1938 on the number of mentally retarded people in provincial institutions related to Orillia. By 1938, however, the number of mentally retarded women at Cobourg had increased to the point where 295 out of 461, or 64 percent of the residents, were classified as mentally defective. Thus beginning in 1943 I include the population "in residence" for Cobourg, and then all subsequent institutions opened for mentally retarded people in the total for the number of mentally retarded people in provincial institutions.

From 1872 to 1964, the number of mentally retarded people in provincial institutions increased continually. In 1964 there were 6,424 mentally retarded people in these institutions. This figure does not include people who may have been in provincial psychiatric facilities, or scattered throughout the provincial institutional system.

Moreover, one must be careful about trying to generalize about trends in the numbers of people in provincial institutions by using the

year-end figures. For example, the decline in the number of people institutionalized seems to have begun in 1964. But the largest drop occurred from 1967 to 1968 when the numbers in hospital declined from 6,246 to 5,656, a decline of 590 residents. But at least 50 percent of that decline can be attributed to the fact that in 1968, 339 mentally retarded people were transferred from the Schedule I facilities to Homes for Special Care. In 1969 a further 628 were transferred, and in 1970, 227. People transferred to the Homes for Special Care were by no means 'deinstitutionalized' in the same sense as someone sent to an approved home, placed on probation, or returned to his family or community. Moreover, although there were mentally retarded people in the Oxford Regional Centre (formally called the Oxford Mental Health Centre, Woodstock) in the late 1960's, they were not formally listed in the totals until 1972. Thus it is extremely difficult to pinpoint an exact date when the decline in the institutional population began. The best one can do is to get a rough idea of the figures, and to date that decline as beginning during the middle to late 1960's.

Table 5. Mentally Retarded People in Provincial Institutions: 1872–1981

Year	In Residence	Discharged: Improved/ Unimproved
	London	
1872	28	
1873	43	
1874	36	
1875	35	
	Orillia	
1876	59	
1877	140	
1878	166	**Hamilton**
1879	155	26
1880	156	66
1881	159	75
1882	248	
1883	231	
1884	235	
1885	229	
1886	218	
1887	210	

Year	In Residence
1888	284
1889	309
1890	312
1891	420
1892	486
1893	513
1894	546
1895	578
1896	605
1897	637
1898	641
1899	657
1900	654
1901	652
1902	659
1903	690
1904	725
1905	742
1906	761

Table 5 (continued)

Year	In Residence	Discharged: Improved/ Unimproved
1907	775	
1908	776	
1909	N/A	
1910	N/A	
1911	809	
1912	817	
1913	823	
1914	823	
1915	831	
1916	828	
1917	992	
1918	987	
1919	1,045	
1920	983	
1921	1,056	
1922	1,142	
1923	1,211	26/14
1924	1,254	28/11

Year	In Residence (excluding those on probation or boarding out)	Discharged: Improved/ Unimproved*	On Probation	Approved Homes
1925	1,299	25/9		
1926	1,321	25/6		
1927	1,326	26/14	36	
1928	1,351	57/14	34	
1929	1,388	53/4	37	
1930	1,411	18/9	40	
1931	1,422	4/0	47	
1932	1,660	22/9	69	
1933	1,785	45	131	
1934	1,805	88	139	
1935	1,769	64	96	
1936	1,847	77	102	
1937	1,829	61	117	
1938	1,909	70	78	
1939	1,968	88	80	13
1940	1,991	80	72	8
1941	2,010	74	92	11
1942	1,983	119	102	106

* *After 1932 figures given are for all those discharged.*

Table 5 (continued)

Year	In Residence (excludes outside hospital)	Discharged	On Probation	Approved Homes	Admissions to Homes for Special Care	Resident in Homes for Special Care: Nursing*	Residential (admitted from Schedule I facilities)	In Homes for Retarded Persons
	All Mental Retardation Institutions							
1943	2,560	162	160	150				
1944	2,604	149	169	129				
1945	2,636	132	158	127				
1946	2,744	105	141	110				
1947	2,735	130	251	84				
1948	2,791	90	138	107				
1949	2,818	108	236	91				
1950	3,035	66	155	123				
1951	3,476	75	342	138				
1952	3,654	145	389	174				
1953	3,879	138	465	161				
1954	4,067	177	535	139				
1955	4,337	170	600	130				
1956	4,643	184	642	129				
1957	4,823	172	719	127				
1958	4,951	176	851	129				
1959	4,965	155	924	134				
1960	5,244	133	877	166				

* *Prior to 1979 there was no data on the number of mentally retarded persons in the Homes for Special Care program who were admitted from psychiatric facilities because their primary diagnosis was listed as mental illness rather than mental retardation. However, in 1979 and 1981 surveys in the program disclosed large numbers of mentally retarded people who had been admitted from psychiatric facilities. These figures are given in parentheses below the figures of those admitted from Schedule I facilities.*

Table 5 (continued)

Year	In Residence (excludes outside hospital)	Discharged	On Probation	Approved Homes	Admissions to Homes for Special Care	Resident in Homes for Special Care: Nursing*	Residential (admitted from Schedule I facilities)	In Homes for Retarded Persons
1961	5,510	N/A	868	214				
1962	5,955	N/A	1,069	213				
1963	6,258	N/A	1,062	38				
1964	6,424	693	1,059	50				
1965	6,308	787	994	90		90		
1966	6,200	873	1,010	199		82		
1967	6,246	N/A	936	275		96	2	
1968	5,656	1,465	1,192	397	339	211	48	
1969	5,472	1,572	1,282	104	628	645	186	
1970	5,357	1,416	1,163	78	227	827	210	232
1971	5,128					938	221	

Year	Schedule	In Hospital	Discharged	On Leave Of Absence	Approved Homes	Admissions to Homes for Special Care	Resident in Homes for Special Care: Nursing/ Residential	Community Residences (Homes for Retarded Persons)
1972	I	5,171	1,194	1,041	159	71	945/224	
	II							
1973	I	6,048	1,619			154	973/248	569
	II	773						

Table 5 (continued)

Year	Schedule	In Hospital	Discharged	On Leave Of Absence	Approved Homes	Admissions to Homes for Special Care	Resident in Homes for Special Care: Nursing/ Residential	Community Residences (Homes for Retarded Persons)
1974	I	5,595	1,863			242	1,074/325	638
	II	761						
1975	I	5,906	1,891	1,115		108	1,088/325	925
	II	774						(beds available)
1976	I	5,694	1,815	995	185	70	1,080/331	868
	II							(beds available)
1977	I	5,376	1,584			43	1,073/322	1,245
	II							(beds available)
1978	I	5,953	1,573	202		39	1,042/321	1,668
	II	1,107						(beds available)
1979	I	5,698	1,604	100		43	987/310	2,395
	II	1,124					(708)(169)	(beds available)
1980	I	5,515	1,598	92	195		964/295	2,684
	II	1,104						(beds available)
1981	I	5,469	1,511	80	180		928/285	
	II	1,092			22		(628)(216)	

Appendix C

For sixty-nine years from 1878 to 1947 the Ontario government published comparative per capita maintenance figures for the various provincial asylums. Included in these figures were expenditures on food, medicine, attendants' salaries, amusements, etc. Until 1893 only gross expenditure figures were published, but after 1893 both gross and net expenditure figures were provided. The latter was arrived at after deducting revenue from paying patients, sales from the insitution farm or factory (at Orillia, for example, the shoe shop did a fairly healthy business during the 1930's).

When one compares the gross per capita expenditures on Orillia with those of the other provincial asylums it becomes immediately apparent that year after year, with depressing monotony, the government spent less per capita on Orillia than any of the other asylums. A quick glance at the table will illustrate this for I have underlined the figures for Orillia during those years when per capita expenditure at Orillia ranked lowest among all the provincial mental health and mental retardation institutions. In terms of gross expenditures Orillia ranked lowest for forty-two out of sixty-five years for which figures are available, and for twenty-one of forty-four years for which figures are available Orillia also ranked lowest as regards net expenditures. The reason for the difference between net and gross expenditures is that the mental health institutions tended to attract more and wealthier paying patients, thus substantially reducing gross expenditures.

Table 6 Gross and Net Per Capita Expenditures at Toronto, Orillia and Cobourg: 1878–1946/47*

	TORONTO		ORILLIA		COBOURG	
	Gross	Net	Gross	Net	Gross	Net
1878	122.71		136.07			
1879	123.74		127.21			
1880	120.54		130.81			
1881	131.68		119.42			
1882	135.41		129.99			
1883	132.99		121.57			
1884	132.76		123.53			
1885	131.05		115.88			
1886	124.90		131.38			
1887	134.71		124.57			
1888	138.29		158.93			
1889	151.99		150.20			
1890	139.30		139.76			
1891	139.11		145.19			
1892	142.64		118.15			
1893	140.22	86.70	118.82	113.29		
1894	143.46	90.87	118.58	113.21		
1895	137.76	82.25	124.45	119.19		
1896	136.11	79.92	98.09	91.04		
1897	139.37	84.71	105.83	97.13		
1898	142.81	92.84	97.37	92.29		
1899	141.14	89.70	89.98	82.39		
1900	139.91	81.82	81.84	76.94		
1901	139.54	82.65	103.24	97.08		
1902	136.25	79.04	92.66	84.44		
1903	157.35	103.35	96.00	88.02		
1904	146.69	89.25	108.15	101.99		
1905	150.57	81.22	96.39	89.42		
1906	165.00	99.00	101.00	86.00		
1907	170.00		103.00			
1908	173.00		103.00			
1909	167.00		100.00			

* *When underlined figure was lowest among all provincial mental health and mental retardation institutions for that year.*

	TORONTO		ORILLIA		COBOURG	
	Gross	Net	Gross	Net	Gross	Net
1910	171.00		104.00			
1911	177.00		114.00			
1912	190.00	120.00	131.00	104.00		
1913	184.00	126.00	132.00	103.00		
1914	184.00	125.00	133.00	105.00		
1915	163.00	108.00	133.00	101.00		
1916	162.00	110.00	144.00	116.00		
1917	184.00	130.00	159.00	133.00		
1918	227.00	126.00	181.00	148.00		
1919	234.00	175.00	189.00	152.00		
1920	356.00	282.00	246.00	212.00		
1921	374.00	278.00	254.00	224.00		
1922	328.00	242.00	255.00	214.00		
1923	371.00	307.00	216.00	185.00		
1924	367.00	380.00	218.00	172.00		
1925	361.00	293.00	219.00	170.00		
1926						
1927	379.00		241.00			
1928	378.00	362.00	296.00	232.00		
1929	395.00	349.00	325.00	296.00	290.00	284.00
1930	398.00	334.00	353.00	304.00	309.00	294.00
1931	358.00	256.00	338.00	259.00	300.00	237.00
1932	330.00	243.00	300.00	228.00	302.00	244.00
1933						
1934	324.00	257.00	293.00	233.00	348.00	279.00
1935	365.00	300.00	299.00	248.00	420.00	364.00
1936						
1937/38	368.00	292.00	287.00	220.00	387.00	327.00
1938/39	346.00	273.00	266.00	197.00		
1939/40	352.00	274.00	268.00	194.00	364.00	299.00
1940/41	361.00	283.00	272.00	198.00	353.00	293.00
1941/42	354.00	267.00	278.00	205.00	362.00	300.00
1942/43	359.00	279.00	283.00	211.00	354.00	248.00
1943/44						
1944/45	397.00	311.00	333.00	249.00	355.00	299.00
1945/46	420.00	335.00	387.00	298.00	342.00	289.00
1946/47	523.00	430.00	443.00	350.00	356.00	293.00

Appendix D

Interviews

The following is a list of people who helped me with this study. The reader will have noticed that some remarks in the text are attributed to anonymous sources. The reason for this is that some of those whose names are listed here were unwilling to have their remarks directly attributed to them. In addition, I interviewed some people who wanted to remain anonymous and their names are not included in the list.

Jane Anderson, Staff, OAMR
Betty Anglin, Board of Directors, OAMR
R.G. Anglin, former President, OAMR
Howard Ross Beattie, former Superintendent, Special Education Services, Department of Education
Dr. Jean Bowers, former Officer, Department of Education
John Boyd, former psychologist, Ontario Hospital, Orillia
Dorothea Crittenden, former Deputy Minister, Ministry of Community and Social Services
L.H. DeLaporte, former Assistant Inspector of Auxiliary Classes, Department of Education
Dr. Matthew Dymond, former Minister of Health
W. Fraser, Administrator, D'Arcy Place, Cobourg, Ontario
Dr. Ron Farmer, General Manager, Mental Retardation Facilities Services Division, Ministry of Community and Social Services

Alan Gordon, former Associate Secretary of the Cabinet
Bonnie Graham, Principal, Queen Elizabeth School for the Retarded, Goderich, Ontario
Paul Green, Associate of W. Williston
Professor Cyril Greenland, School of Social Work, McMaster University
Dr. John D. Griffin, former General Director, Canadian Mental Health Association
Dr. Bernard Graney, National Institute on Mental Retardation
John N. Haddad, Executive Director, OAMR
Dr. H. Jackman, Senior Policy Analyst, Provincial Secretariat for Social Development
John Kelley, Policy Analyst, Ministry of Community and Social Services
David MacCoy, former Director, Mental Retardation Community Services Development, Ministry of Community and Social Services
Donald MacDonald, MPP
Ian MacDonald, former Deputy Treasurer
Christie MacMillan, Librarian, Huronia Regional Centre
Jack E. McKnight, Senior Advisor, Federal Provincial Cost Sharing, Ministry of Community and Social Services
Ross McClellan, MPP
Dr. B.H. McNeel, former Chief, Mental Health Division, Ministry of Health
Professor C.R. Myers, Department of Psychology, University of Toronto, formerly with Ontario Hospital, Orillia
Dr. Carl Rubino, Director, Surrey Place Center
Dr. Allan Roeher, former Director, National Institute on Mental Retardation
Angus Robertson, former President, OAMR
Margot Scott, former President, OAMR
John Seymour, Executive Director, Barrie Association for the Mentally Retarded
James Taylor, former Minister of Community and Social Services
Elva Telfer, former member Board of Directors, OAMR
Jim Turner, former President, Metropolitan Toronto Association for the Mentally Retarded
John Webster, former Director, Mental Retardation Community Services Development, Ministry of Community and Social Services
Robert Welch, former Provincial Secretary for Social Development Policy
Walter Williston, author, *Williston Report*

John Wilson, Ministry of Community and Social Services
Murray Yewer, Program Analyst, Ministry of Community and Social Services
Dr. Donald Zarfas, Professor, University of Western Ontario, Children's Psychiatric Research Institute.

Glossary of Acronyms

AMR	Association for the Mentally Retarded
CCF	Co-operative Commonwealth Federation
CNCMH	Canadian National Committee on Mental Hygiene
COGP	Committee on Government Productivity
COMSOC	Ministry of Community and Social Services
COS	Charity Organization Society
CPRI	Children's Psychiatric Research Institute
FBA	Family Benefits Act
MTAMR	Metropolitan Toronto Association for the Mentally Retarded
NACFM	National Association for the Care of the Feeble-Minded
NDP	New Democratic Party
NIMR	National Institute on Mental Retardation
OAMR	Ontario Association for the Mentally Retarded
OARC	Ontario Association for Retarded Children
OPSEU	Ontario Public Service Employees Union
PACFM	Provincial Association for the Care of the Feeble-Minded
PLA	Provincial Lunatic Asylum
TEIGA	Ministry of Treasury Economics and Intergovernmental Affairs

Bibliography

There is an enormous wealth of information on mental retardation policy in Ontario to be found in the *Ontario Sessional Papers*, or, prior to 1867, in the *Sessional Papers* of the Province of Canada. The various asylum superintendents and inspectors wrote lengthy, detailed and critical reports until the 1920's. After that point the reports become increasingly terse, although they still include a mass of statistical data. There is no other comparatively rich source of information outside the *Sessional Papers*. The Provincial Archives has files on the various Premiers, Provincial Secretaries and Ministers of Health, but information on mental retardation policy is scanty. The Public Archives of Canada has information on pressure groups such as the National Council of Women of Canada, but no specific information on mental retardation policy in Ontario. Mental Health Canada has extensive archives on the Canadian National Committee for Mental Hygiene but these are relevant only for a brief period during the 1920's and 1930's when the CNCMH was concerned with the question of mental retardation. The archives at the Huronia Regional Centre (Orillia) have little relevant material. One potential source of information is the various Toronto newspapers but none of them has indexes, except for the *Globe and Mail* which only began indexing recently. Even the debates in the Ontario legislature were officially recorded only after 1945, and although there is the so-called "newspaper Hansard" it is by no means complete or exhaustive. As regards other sources of information, one important periodical is the *Journal of Psycho-Asthenics* which first began as the *Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons* in 1877. It became a journal in 1898 and then

the *American Journal of Mental Deficiency* in 1940. However, like another useful source, the *Journal of Insanity* which began publication in 1844, the *Journal of Psycho-Asthenics* focussed mainly on American issues, with occasional articles about Canada or by Canadians. As regards mental retardation policy in Ontario, except for the Williston Report, there is no full-length study available, and only a few articles in various journals.

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from ASYLUM to WELFARE

Harvey G. Simmons

From Asylum to Welfare is the first comprehensive, analytical study of a major social policy in Ontario. Drawing on a wide variety of sources, including archival material, government documents and personal interviews, the book combines social history and social policy analysis.

The author argues that mental retardation policy in Ontario has always sought to achieve four major objectives: to provide asylum for mentally handicapped people who could not have survived in the community because of severe physical or mental handicap; to educate mentally handicapped people defined as educable; to provide social control for mentally handicapped people who were considered a threat to existing societal beliefs or values, and to provide welfare for those people who could only function in the community with government support.

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